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# The JOURNAL

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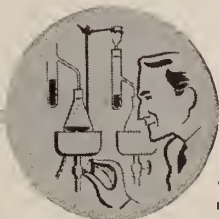
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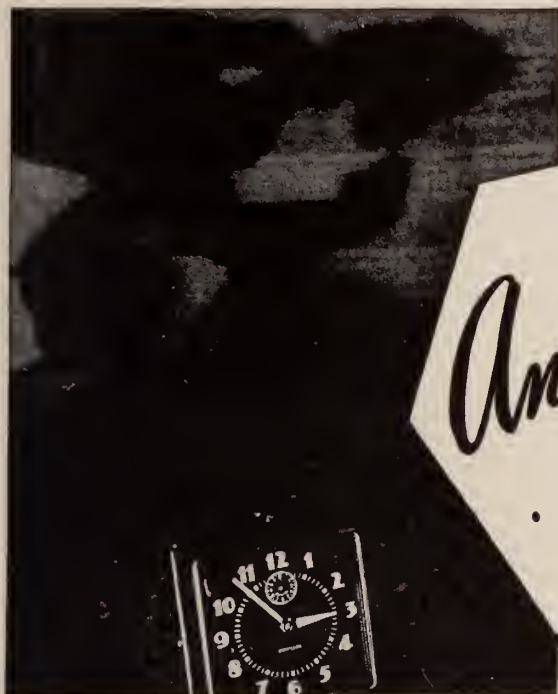
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- ☐ Laryngoscope, 1935, XLV, No. 2, 149-154—"Some Clinical Observations on the Influence of Certain Hygroscopic Agents in Cigarettes."
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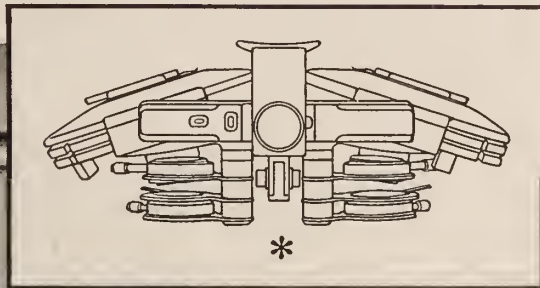
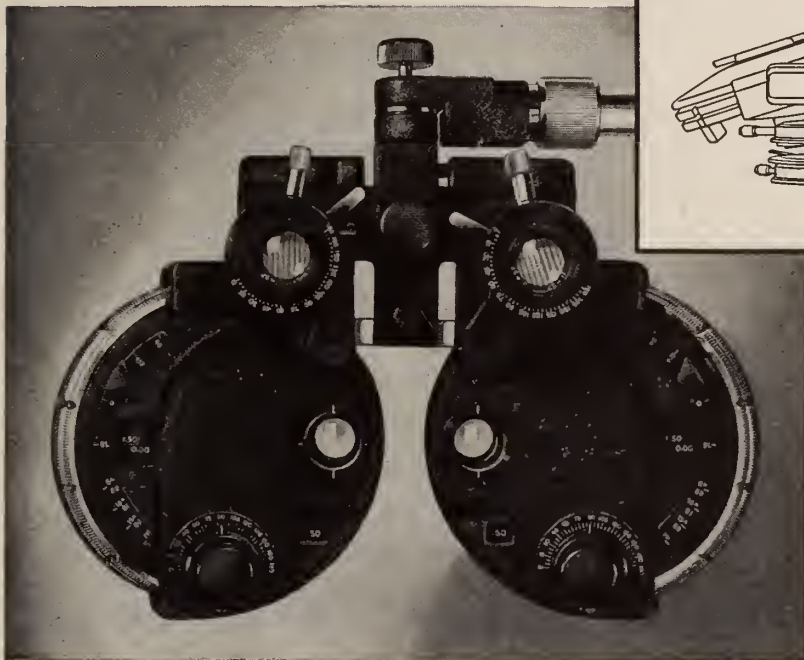
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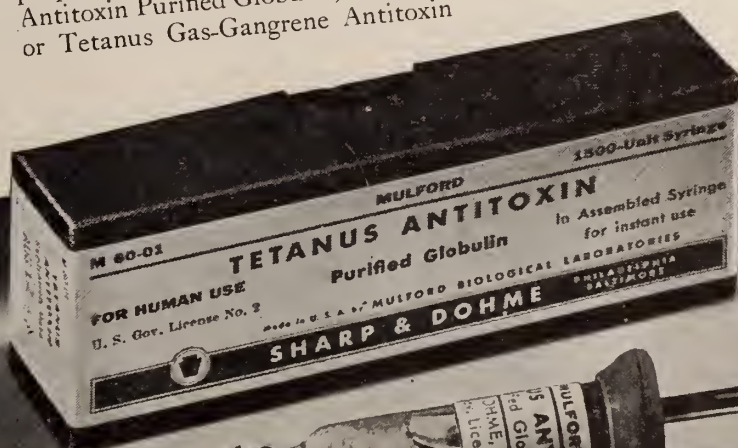


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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

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Number 1

## BRAIN ABSCESS

JOSEPH E. J. KING, M.D.

New York, N. Y.

It is the intention of the author to present this paper in ordinary, everyday language, having in mind the multiple interests of this audience in contrast to a group more specifically interested in neurology and neuro-surgery.

A brain abscess may be located in the cerebrum, cerebellum or brain stem. This paper concerns itself only with those in the cerebrum and cerebellum. An abscess may be termed acute or chronic, for the sake of discussion, although the surgical definition of a true abscess carries with it the meaning that the lesion is circumscribed and walled-off. In the beginning of the process, the condition is that of localized encephalitis regardless of the method of introduction of the infecting organisms. There is an inflammatory leukocytic infiltration with edema. The surrounding brain substance becomes softened, breaks down and necrosis ensues. The necrotic area liquifies and becomes a small "core" of pus and detritus contained in an ill-defined cavity without a real wall. About this suppurative focus, necrosis of the brain substance lining the irregular, non-encapsulated cavity continues with formation of more pus. The cavity is lined with shaggy necrotic tabs of hemorrhagic brain tissue. Beyond the necrotic zone there is a layer of markedly edematous brain substance. The edema is marked and extends most rapidly in single metastatic lesions.

The suppurative process may extend, without being limited, into the meninges or ventricle, which may prove fatal. Should the protective reaction of the brain be sufficient, the suppurative process becomes limited, the edematous area is lessened, the accumulated pus is walled-off or "encapsulated" and a chronic brain abscess results—a most fortunate occurrence.

The wall of the abscess may have a thickness of from 1 mm. to  $\frac{1}{4}$  or  $\frac{1}{2}$  inch, the usual thickness observed being about 2 to 4 mm., requiring from three to five weeks in its formation. The wall may be so firm that the lesion could be mistaken for a solid tumor. In fact, instances are reported in which the entire abscess was removed as a tumor, and its true identity was not detected until sectioned.

The type of organism producing the abscess and the amount of resistance offered by the brain substances influence the formation of an abscess wall. In cases where certain anaerobic organisms are present, there is little tendency to walling-off. The wall may be quite firm, thick and resistant, due to the presence of a larger amount of fibrous tissue. On the contrary, some well-defined abscess walls, even though 2 to 4 mm. thick, are soft, friable and easily perforated or torn. All are not alike in this respect.

The wall is thickest at the pole of the abscess near the involved bone, external pole in temporal and frontal abscesses and anterior or internal pole in most instances of cerebellar abscesses. The inner wall, the so-called "pyogenic membrane," is fairly smooth. The color of its inner surface is usually yellow or pinkish yellow. The outer wall usually has the dark brownish-red color of a decaying cherry, or it may be gray.

In an early abscess that is not encapsulated, and before definite, firm encapsulation has taken place, the contents are not homogeneous. They consist of a supernatant yellow, oily, murky liquid, and a residual thicker fluid made up of pus and brain debris or detritus. In chronic abscesses with a firm wall, the pus is usually thick and yellow, or greenish-yellow. It may have no odor, or the pus may be very fetid and foul-smelling.

The shape of most abscesses is ovoid, with the smaller pole directed toward the infected bony cavity from which the infection spreads to form the abscess. Other abscesses, especially single, metastatic lesions, are more likely to be spherical. In instances where the abscess has spontaneously evacuated itself through

Delivered by invitation at the Sixty-sixth Annual Meeting of the Florida Medical Association, Daytona Beach, May 1, 2, and 3, 1939.

the cribiform plate or through the external auditory canal, the abscess may be the shape of a fig, surrounded by pericapsular purulent necrotic brain substance.

Abscesses most amenable to surgical treatment range from the size of a large malaga grape to that of an orange. The usual size is about that of a golf-ball or a tangerine. The amount of pus contained varies from one or two teaspoonfuls to over seven ounces, the most observed by the author in which recovery took place. The average capacity is from 1-3 ounces in cerebral, and about 1 ounce or less in cerebellar.

Any of the pyogenic organisms may produce a brain abscess, the most common being *Streptococcus haemolyticus*. Some are due to the pneumococcus, the staphylococcus, colon bacillus, etc., or the organisms may be mixed. Some abscesses contain sterile pus.

#### SOURCE OF INFECTION, AND LOCATION OF ABSCESS

1. Otitic infections: mastoiditis, otitis media, necrosis of the petrous pyramid, thrombosis of the lateral sinus, etc.
2. Infections of the accessory nasal sinuses.
3. Metastatic.
4. Various diseases of the skull: osteomyelitis, malignancy, actinomycosis, etc.
5. Traumatic.

Abscesses resulting from otitic infections are usually located in the homolateral temporal or cerebellar lobe, or both, the temporal region being more commonly involved. Involvement of the contralateral hemisphere may take place, in which case the infection spreads through the sinuses. This is not common. The temporal portion of the temporosphenoidal lobe is involved more often than the sphenoidal. In the case of cerebellar abscesses, the outer inferior portion of the lobe is more frequently the site of the lesion, but it may be central in position.

An abscess secondary to infections of the nasal accessory sinuses usually involves the frontal lobe. It occupies, as a rule, the anterior pole of the lobe extending backward, upward and outward, external to and above the anterior horn of the lateral ventricle. However, it may be situated in the lower internal portion of the lobe nearer to the falx and base than to the cranial vault. The homolateral lobe

is usually the one involved but the abscess may be in the opposite lobe, and the lesion is sometimes bilateral.

Metastatic abscesses are single in about 50 per cent of cases, and may be amenable to surgical treatment, while 50 per cent are multiple and hopeless. Single abscesses are most common in the left cerebral hemisphere,—frontoparietal, frontal, parietal, or occipital, in order of frequency. The cerebellum is seldom involved. Single abscesses are usually large, originate in the white matter and encroach closely upon the lateral ventricle.

An abscess resulting from osteomyelitis may be single or multiple, and is usually situated near or adjacent to the suppurative process in the bone.

Traumatic abscess may be situated in any part of the brain, especially when it is associated with a foreign body. The cerebral hemisphere, being more exposed to penetrating compound fractures of the skull, is often the site of a traumatic abscess.

Let us now consider the individual abscesses—namely, temporal frontal, cerebellar, traumatic and metastatic with regard to their origin, symptoms and diagnosis.

#### TEMPORAL LOBE ABSCESS

Abscess occurs more frequently in the temporal lobe than in any other part of the brain. It is secondary, as a rule, to otitic infections and its presence may be recognized either before or after a mastoidectomy has been performed. A common picture is that of the patient who has had a chronic, purulent discharge from the ear for a long time, or mastoidectomy has been performed and the patient is not doing well afterwards. The wound does not heal completely or as well as it should. There is a continuation of foul-smelling purulent discharge from the ear or the discharge may have ceased rather suddenly. Cholesteatoma, with necrosis of the dural plate and pathological exposure of the dura, may be found. The cortex of the mastoid may be hard and eburnated like ivory, while the bony areas near the dura may be soft and partly destroyed by the disease. The abscess may have existed for some time and a mastoidectomy may not have been performed.

The infection spreads from the diseased area in the middle ear along the following pathways:



a. Necrosis and perforation of the roof of the tympanic cavity. An extradural abscess may be present. The dura and other meninges become adherent to the necrotic bone area and to the brain, and the infection spreads directly into the brain substance and an abscess forms. Most of these occur in patients between 20 and 40 years of age for the reason that the roof of the tympanic cavity is much thinner and more friable in adults than in children. The external portion of the wall of these abscesses is situated very near the surface, may have a "stalk" connecting it with the diseased area in the skull, and may even perforate the wall spontaneously and discharge large quantities of pus through the external auditory canal.

b. Infection may extend or spread along the perivascular spaces of perforating blood vessels. In such instances the abscess wall is at a greater distance (1-3 cm.) from the meninges covering the temporal cortex. There may be no gross changes in the cortex.

c. Purulent thrombosis of the lateral sinus may be followed by abscess formation in the temporal lobe, but it is more frequently the cause of a cerebellar than a temporal abscess.

d. The infection may pass through the internal auditory meatus but this seldom occurs. Petrositis involving the tip of the petrus is more likely to produce meningitis than brain abscess.

*Symptoms and signs of temporal lobe abscess.* Symptomatology and neurologic signs vary considerably with regard to the stage of development of the abscess. Pain in the ear, later in the head, is one of the first symptoms. The pain is located in the temporal region but radiates to the frontal and less frequently to the occipital region. It is not called a "headache" by the patient, but "pain." The pain is severe and sometimes excruciating so that the patient may cry and moan. In children the crying is hard and prolonged and not the sudden short outburst of crying observed in well-developed meningitis. The pain may be intermittent or continuous. Seldom does one fail to obtain the history of pain if the patient or family is carefully questioned. The pain is due to the rapid increase of intracranial bulk resulting from the suppurative encephalitis accompanied by marked edema. Loss of appetite and vomiting, not usually associated with nausea, occur early. A mild or severe chill, or chilly sensation is experienced early in most

cases, lasting from a minute or two to a half hour.

The pulse and temperature are elevated at first, more in children than in adults. There is no choking of the discs or engorgement of the veins at this time. There is marked prostration; the tongue is coated, and there is a foul odor to the breath. During this time, in the first two or three days, the diagnosis of the true condition is seldom made, though it may be suspected. High fever, stiff neck, and the Kernig sign are present only when meningitis accompanies the formation of the abscess.

Should the suppurative area not be limited, the process usually extends into the ventricle, meninges, or both, and suppurative leptomeningitis ensues, followed by death. Should the process be limited and circumscribed and a definite wall be established, the symptoms and signs change in character and degree. The pain is not so severe in many instances, but may be marked in others. The patient may not complain so much of the pain on account of the general diminished sensibility, diminution of the encephalitis and edema, or both. It is believed to be due for the most part to the former, i. e., diminished sensibility, for there is still marked increase of intracranial pressure and the hemisphere containing the abscess is always much larger than normal. The patient as a rule becomes lethargic, stares vacantly, and there is a loss of cerebration and attentiveness amounting to a dreamy state. One may gain the patient's attention by sharply spoken words or commands, but soon he lapses into an inattentive, listless condition.

The temperature ranges from normal to 102 F. Although some observers state that the temperature is normal or even sub-normal, most of the patients whom I have observed have registered a rectal temperature of between 100 and 102 F. No one has satisfactorily explained why the low temperature exists. The pulse becomes slow, and may be as low as 45 or 50 per minute or less. It may be normal, but not increased except in complicated cases. The respiration rate is also lowered, but is usually regular.

There is rapid loss of weight. (On recovery, the gain in weight is likewise rapid). The breath is very foul, and the teeth are covered with dirty yellow material.

Paresis of the face on the contralateral side is to be expected, but it never reaches the de-

gree of paralysis seen on the homolateral side due to the physiological or anatomical interruption of the facial nerve by disease or operation upon the mastoid. Only in large abscesses or in those with extensive edema does one observe paresis of the arm of the opposite side, and rarely is the lower extremity involved. Sudden hemiplegia of the opposite side is never seen except in instances of suppurative leptomeningitis or metastatic lesions.

Aphasia in some form is usually present in lesions of the left temporal lobe in right handed patients and vice versa. The most frequent form is anomia, the use of the wrong word. The next most frequent type is circumlocution, the inability to name an object though able to state its use. There may be inability to write or spell. Motor aphasia is seldom observed and, when it is, one may know that the abscess is large and extends farther forward than usual.

Ophthalmologic examination usually gives interesting data. The pupil may be dilated as a result of pressure on the third nerve. Seldom is the nerve completely paralyzed, and then only if meningitis is present. There may be paralysis of the sixth nerve with inability to look outward, the nerve involvement being due to highly increased intracranial pressure or to concomitant petrous tip involvement. The most constant finding is engorgement of the retinal veins, usually more marked on the homolateral side. Hemorrhages, fresh and old, may be seen, especially in abscesses which have existed for several weeks. Papilledema is not observed early, but may be marked, 3-5 diopeters, by the time the patient comes to operation. The amount of swelling of the discs does not determine the size of the abscess. If the patient is cooperative, quadrantic or hemianoptic defects may be determined. These are of value in localizing the lesion. Astereognosis is often demonstrated in cooperative patients.

The deep reflexes are usually increased, greater on the opposite side. The Babinski sign on the contralateral side may or may not be present. The abdominal reflexes are usually diminished on the opposite side.

Lumbar puncture often reveals clear fluid under pressure, well over 200 mm. of water. The cell count may be normal but is usually increased, 20, 50 or 100 or more per cm. Before encapsulation takes place the cells are predominantly polymorphonuclear cells. When

the cells are predominantly lymphocytes, it is an indication that walling-off of the abscess has been completed. Although rapid removal of a large quantity of cerebro-spinal fluid may result in a fatality, it is not believed that the slow removal of about 2 cc. of fluid through a small needle for diagnosis is ever followed by untoward results. In fact, a careful lumbar puncture may, at times, be of therapeutic value.

The leukocytic and polymorphonuclear cell count are increased as a rule, the former ranging between 11,000 and 18,000 with an average of about 14,000 cells per cm. and the latter from 85 to 92 per cent. Only in old chronic, well walled-off abscesses is the count not increased. Radiographic films may be of some value, especially if a pathological exposure of dura has occurred.

You have heard the words "usual" and "likely" repeated. From this one can readily infer that all cases do not always present these signs and symptoms, especially when first seen by the neurologic surgeon. The patient may be in such profound stupor or coma that no history is obtainable from him, and very little definite information can be had from relatives or friends. On the other hand, the abscess may be so well walled-off, benign and innocuous that no sign or symptom is present, and the fact that an abscess exists may not be determined except at autopsy. Such may be the extremes in signs and symptoms.

The abscess may become calcified and give no further trouble. The contents may become sterile, the lesion quiescent, and no trouble develop until the patient sustains a trauma, like a blow on the head. Then the abscess may increase in size and rupture spontaneously into the meninges or ventricle with fatal termination. One of these complications usually arises if the abscess is not successfully operated upon, but the patient may survive, ignorant of the presence of a brain lesion of any kind and die of other causes. The abscess may rupture spontaneously through the ear, but cure is not likely to be effected by so doing. Although death may result from greatly increased intracranial pressure which paralyzes the medullary centers, it is more likely to follow sudden rupture into the ventricle or meninges. In the former, death results in about 6 to 8 days, and in the latter, within 36 hours.

*Diagnosis.* One would be justified in concluding that a diagnosis should be made read-



ily and easily after considering the points enumerated. In some instances this is so, and the diagnosis can be made almost as readily as in the ordinary case of acute gangrenous appendicitis. Unfortunately, this is not always the fact. At times, diagnosis and localization of a brain abscess may be extremely difficult, —sometimes even impossible.

When in doubt, one should resort to ventriculograms. Any case of temporal abscess which lends itself to operative interference will produce displacement and distortion of the lateral ventricles. Ventriculography is preferred to encephalography and is believed to be safer in these cases. Accurate localization of the abscess is most important if a successful outcome is to be expected. Indiscriminate exploratory punctures with a cannula, or exploratory punctures through an infected field can be mentioned only to be strongly condemned.

Temporal abscess should be differentiated from middle ear disease with adjacent edema of the brain, "serous meningitis," extradural abscess, sinus thrombosis, brain tumor, spontaneous subcortical hematoma, chronic subdural hematoma, and abscesses in other portions of the brain. Time will not permit consideration of these topics.

#### FRONTAL LOBE ABSCESS

An abscess in the frontal lobe gives rise to the same general symptoms and signs as a well developed abscess in any other part of the cerebrum, namely, pain in the head, nausea and vomiting, foul breath, prostration, rapid loss of weight, slight elevation of temperature, slow pulse, fundi changes, leukocytosis, findings in the cerebrospinal fluid, changes in reflexes, slow cerebration, drowsiness, stupor, and coma.

Localization and lateralization are usually much more difficult than in any other abscess. In fact, the neurologic findings may be very meagre, almost to the point of being nonexistent. When the general symptoms and signs of a brain abscess are present in a given case, the mere lack of localizing signs would make one choose the frontal lobe as the probable site. This is true especially if the abscess is small, or has reached a very chronic stage. The abscess may be very large, almost unbelievably so, and it is only when the abscess or the surrounding edema is extensive that

lateralization may be determined. As the abscess or surrounding edema progresses backward, the two most helpful findings present are aphasia, when the predominant lobe is involved, and paresis which the lesion produces. Paresis of the opposite upper extremity (weakened grip, etc.) occurs first, followed by that of the lower extremity and last, if at all, of the face. In temporal abscess, the paresis is noticed first in the face, then arm, and last, if at all, in the lower extremity. Flaccid hemiplegia has never been observed except when the abscess has ruptured into the meninges. Rupture into the ventricle will otherwise occur before the abscess produces complete hemiplegia.

Dilatation of the homolateral pupil and unilateral loss of smell are of value in determining which lobe is involved. X-ray films of the sinuses and the operative site may suggest the side involved, although the abscess may develop in the frontal pole opposite to the operative site, or it may be bilateral.

In an instance where one has very definite reasons for believing that an abscess is situated in a frontal lobe, exploratory puncture is advisable. If negative, ventricular puncture for ventriculography can be made through the burr hole. Where signs and symptoms are not of lateralizing value, ventriculography is preferred. The ventriculograms will show marked compression and displacement of the ventricle backward and downward.

#### CEREBELLAR ABSCESS

Cerebellar abscess is more frequently found in children and younger people than in adults. The abscess is usually located in the lobe adjacent to the involved mastoid or lateral sinus or both, is more frequently situated in the external portion of the lobe, and is smaller than the usual cerebral abscess. Frequently it is the shape of a bird's egg, with the smaller pole directed forward and firmly fixed to the posterior surface of the petrus, from whence the infection extends. However, it may be centrally located within the cerebellar lobe.

From the foregoing one can readily understand what the signs and symptoms might be. As the abscess increases the size and shape of the lobe which it occupies, pressure is made across the midline, resulting in displacement of the medulla and brain stem, producing, as a rule, homolateral pyramidal track signs,

compression and blocking of the aqueduct, causing internal hydrocephalus. This results in marked increase of intracranial pressure, bilateral papilledema, which may be equal, and bilateral frontal headache. Tenderness and pain on percussion may be elicited over that portion of the occipital region beneath which the abscess lies. There is frequently associated soreness and slight stiffness of the neck, more on the involved side than on the opposite. Nystagmus toward the affected side is usually observed.

Diagnostic lumbar puncture must be done with great care. Therapeutic lumbar punctures are banned. For relief of pain, ventricular puncture through a burr hole over the homolateral anterior horn is easily accomplished and should be done in every case. In most cases of cerebellar abscess observed by the author the patients were stuporous or in coma. Following ventricular puncture the mental condition clears up almost immediately and the severe pains are relieved. During this procedure air can be readily substituted for the cerebrospinal fluid and ventriculograms should be made which will show the degree of the dilatation of the ventricles. On the anterioposterior film the lateral ventricles will show moderate symmetrical dilatation, and the third ventricle will appear dilated and in the midline. On the posterior-anterior view the posterior horn on the involved side will be smaller than that of the opposite side. This is due to the pressure exerted from below upward by the increased size of the involved cerebellar lobe, the pressure being transmitted despite the intervening tentorium. In labyrinthitis this does not hold true; therefore, ventriculograms are valuable in differentiating between these two conditions.

#### TRAUMATIC BRAIN ABSCESS

Traumatic brain abscess may follow various kinds of trauma such as punctured wounds of the skull and brain, compound fractures of the skull and gunshot wounds. The abscess may develop rapidly and show definite evidence of its presence in 2 or 3 weeks. It may form many weeks, months or years after the original injury. In a small punctured wound of the skull, dura and brain, the infection is carried directly into the brain, and the production of an abscess is due to direct implantation. This process may likewise follow extensive com-

pound fractures of the cranial vault but if the original wound is properly treated, the subsequent formation of a brain abscess should be rare. Compound fractures of the base of the skull are much more likely to produce meningitis than abscess.

In some cases the original wound may have been sutured and well healed externally, only to be followed several weeks later by signs and symptoms indicating development of an abscess. Simple depressed fractures sometimes involve the mastoid and the frontal sinus and ethmoids in the fracture lines, allow release or spread of pre-existing infection from these structures into the fracture lines, and thus open pathways to the brain, followed by abscess formation.

Associated with partial avulsion of the scalp, infectious material may be ground into the outer table of the skull, local necrosis of the skull may occur, giving rise to an abscess of the brain comparable to one complicating osteomyelitis of the skull.

An abscess may develop spontaneously from latent infection about a retained foreign body in the brain many years after its introduction, or shortly after removal of a foreign body which was retained for many years. In a case observed a large abscess developed at the site from which a piece of knife blade was removed. The piece of knife blade measuring  $3\frac{1}{2}$  inches in length with a saw-tooth edge, had been in the brain for over 28 years, the longest noted interval in the experience of the author.

Abscesses may appear early or late in bullet tracts, with or without retention of foreign bodies. When the abscess is secondary to a punctured wound of the brain, compound comminuted fracture with or without dural laceration, simple depressed fractures of the skull involving the mastoid or nasal accessory sinuses, its location is usually beneath and near the site of the injury. Pus may be seen discharging through the wound, or there may be no discharge of pus. There is always a considerable amount of fibrous tissue formation in the structures overlying the abscess and the communication may be well walled-off. For these reasons, this type of traumatic abscess is especially amenable to operative interference. Another important bearing on the probable prognosis is that the abscess is single in about 90 per cent of the cases. Abscesses about deep-



ly retained foreign bodies offer many more difficulties. Traumatic abscesses which do not communicate with the wound, and therefore do not discharge pus, present general symptoms and signs observed in cases of any well formed abscess of the brain. Should pus be discharging from the wound, symptoms and signs will usually be to a lesser degree on account of the continuous decompressive effect.

#### METASTATIC BRAIN ABSCESS

About 50 per cent of these cases are multiple, and therefore hopeless. In the cases of a single abscess, the surrounding edema and softening of the brain is more extensive than that present in any other form of brain abscess. It is always in the white matter. For these reasons earlier rupture into the ventricle, and not into the meninges, occurs. A fatal result ensues within 2 or 3 weeks in the majority of cases. On the other hand, encapsulation may occur but all of these abscesses are large and encroach closely upon the ventricle. The intervening wall may be so thin that it appears translucent after evacuation and inspection of the abscess cavity, and there is grave danger of ventricular rupture from the ventricle into the abscess cavity if the postoperative increase of intraventricular pressure is not controlled by lumbar punctures.

Since the abscesses are usually in the frontoparietal, parietal or occipitoparietal regions, localizing signs and symptoms such as hemiplegia, hemianesthesia, homonymous hemianopia and aphasia, are frequently present, and localization is readily made.

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*Prognosis* is good in all cases of single uncomplicated, well walled-off abscesses. This opinion is not universal, and previous to the last two decades, recovery was not expected by physicians or laymen. When a patient recovered, luck was thought to have played a big part. Sir William MacEwen of Glasgow in his outstanding book *Pyogenic Diseases of the Brain and Spinal Cord* published in October, 1893, held a different view and even then stated in one of the concluding paragraphs: "One might almost conclude that in uncomplicated abscess of the brain, operated on at a fairly early period, recovery ought to be the rule."

*Treatment.* All of the extradural foci should

be eradicated. Operations upon the mastoid and sinuses, without the use of mallet and gouge, should have been completed. Many "brain abscess pictures" will clear up, due to the fact that the condition was caused by edema, extradural abscess, etc. The treatment of the abscess is surgical. This statement does not imply that the operation has to be done immediately in all cases. With the exception of cases of single, acute metastatic abscess, it is best that the operation be done after the third or fourth week, at which time complete walling-off and encapsulation of the abscess is expected. The increase in the cerebrospinal fluid cell count, changing of the nature of the majority of cells from neutrophils to lymphocytes, is indicative of better encapsulation. Should operative interference be advisable, supportive dehydrating measures should be adopted. Blood transfusions may be indicated. Intravenous administration of 100 cc. of 50 per cent solution of sucrose is probably the best dehydrating agent. Its dehydrating effect is more prolonged than that of glucose; its results are striking in some cases of abscess. It has been observed that a change from deep coma to that of clear mentality has followed administration of sucrose or glucose and the reverse was true when the solution was withheld.

When the proper time for operation on a cerebral abscess has been determined, the open method is preferred to the closed method of tube drains or tapping. With the open operation, advocated by the author in 1923 and used by him since that time, the overlying bone, dura, and cortex are removed, the bony opening measuring about 3 to 4 cm. in diameter. Most abscesses amenable to surgery are situated not more than 2 cm., and frequently much less, from the dura. This has been observed many times at operation and in museums. Through a dural opening of the size suggested, necrotic brain and pus outside an abscess cavity are removed. After removal of the presenting portion of the abscess wall, the cavity is readily evacuated and inspected. Secondary pockets or extensions may thus be detected and dealt with. These pockets could not conceivably be drained by tubes, through a small drain, as is used in the closed method. Slow controlled elevation of the floor of the abscess to the level of the skull accomplishes extinction of the abscess cavity, prevention of

secondary pockets, rupture into the ventricle and meningitis. Iodoform gauze is used in the cavity and the area is well dakinized until healed. The entire area is healed in from 35 to 60 days. Scalp plastic with excision of the scar is done after six months.

Drainage tubes are used *only* in cerebellar abscesses, where there is no ventricle to be considered; where, in the majority of cases, the anterior pole of the abscess is fixed to the infected petrus by adhesions which should not be separated and where prolonged drainage of this area is proper. Furthermore, no elevation or herniation of the floor of the abscess should be permitted on account of shifting or torsion of the brain stem and medulla. Preliminary ventricular puncture should always be done.

#### RESULTS

Sixty cases of brain abscesses of all types, including those of metastatic origin, have been observed since 1920, and a number of traumatic abscesses and brain fistulae were observed during the 4¼ years' service with the German and American armies during the World War. Many had been previously operated upon or tampered with before coming under the observation of the author. Of these 60 patients, 29 died and 31 survived. Of the former, 8 were frontal, 8 were temporal, 3 were cerebellar and 10 metastatic (8 multiple, 2 single, all cerebral.)

In 3 of the early cases in 1920 and 1921 tube drains were used before the open method was introduced; in 1 frontal, the tube became displaced and in an attempt by an assistant to replace it, the tube was placed into the brain substance outside the drainage tract; in 1 frontal the tube perforated the ventricle; in 1 temporal the tube was removed too early and a secondary pocket ruptured into the ventricle. Eight were multiple, metastatic, and therefore, hopeless; 2 were large single metastatic abscesses, in which the dilated ventricle ruptured into the evacuated abscess cavity through the thin interval before the introduction of lumbar puncture to reduce intraventricular pressure. Two were acute abscesses, 1 with blood stream infection of *Staphylococcus aureus*, and 1 patient was moribund and was tapped only to satisfy the family. Six cases were complicated by suppurative leptomeningitis at time of operation, 1 bilateral frontal.

Three were cerebellar; one patient died

following mastoidectomy, aspirated after death; one when seen was moribund due to jamming of the conus in the foramen after repeated lumbar punctures and extension by rupture of abscess against the pons; one early case in which the wire cone drain was used.

One patient with frontal lobe abscess recovered from the original abscess and died later from a second abscess formed from reinfection, or lighting up of the infection in an improperly operated frontal sinus. Ventriculograms would have located this abscess.

Four patients were operated upon according to the method advised and should have recovered but died as a result of mishaps or accidents: 1 temporal, in a six-year-old girl who died of pneumonia following dakinization and being placed by an open window in the winter; 1 temporal, in which the patient, who was in a distant hospital, removed the dressing and tore the brain substance with her fingers; 1 temporal, well walled-off, in a comatosed woman who had a temperature of 104 F. and insufflation pneumonia, due to pouring eggnog down her trachea. (At autopsy, egg and milk were found in the lungs); 1 temporal, in an unmanageable coastguardsman, who got out of bed on the sixth postoperative day, and the abscess ruptured into the ventricle. One patient with frontal lobe abscess died before being seen following rupture into the ventricle.

Of the 31 patients who survived, 8 had frontal abscess, 10 temporal, 5 cerebellar, 5 traumatic, and 3 metastatic, one of which was acute, operated upon on the sixth day after onset, and 2 were well walled-off large abscesses. Four were not operated upon by the author, but operation, management, or both were under his direction. In 2, one frontal and one temporal, there was gross rupture into the ventricle, with associated meningitis, loss of consciousness, and loss of sphincter control.

Thirty-five patients were operated upon according to the methods described, four of whom died, two of preventable pneumonia, one from tearing the brain after removal of a dressing in a distant hospital, and one from rupture into the ventricle due to getting out of bed on the sixth day.

In all cases only one operation for brain abscess was required. Multiple procedures were never done. No patient has had post-



operative convulsions except 4 who had convulsions before operation.

As experience with these cases has increased and earlier observation of the brain abscess suspect has been made the results have been better. The last 20 consecutive patients, with one exception, recovered.

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## THE GALLBLADDER

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A first-year medical student once described the gallbladder as "that small green thing that ruins the chicken liver." He probably little realized that his facetious definition, broadened somewhat, could be made startlingly factual.

From an eminent clinician came a definition of this same organ: "A diverticulum of the bile channels, at whose door, in the human family, can be laid responsibility for uncounted disorders, the relief of which often harasses the medical profession with the perplexing question of 'when to do what.'"

A diverticulum! Consideration of the physical characteristics of the bile channels gives appropriateness to the descriptive term, for we shall see the gallbladder as a universally present, natural diverticulum superimposed as a switch-back on the route of bile flow from the liver cells to the duodenum. That it has a definite and specific function in the body-economy, experimental investigation has expended much labor to prove, despite the irrefutable evidence its mere presence in the body affords. That its function is complex, agreement is unanimous. Regarding the exact nature of these complexities of functions, their inter-relationship with each other, with that of the liver, the gastro-intestinal tract and other more distant individual and group organs, lively discussion has long existed, for certain irrationalities intrude themselves into the relationship of the biliary functions to our modern highly-complex scheme of life. Most certainly the ever-changing mode of living of the human race has complicated what once must have been a smoothly operating adjunctive function to the appropriation and utilization

of food by man. We cannot but subscribe to the belief that ancient man bore up under vastly fewer vagaries of gallbladder function and dysfunction than does his unhappy modern day successor.

Let us give consideration to the gallbladder for what it is—a natural and functionally related segment of a highly important component part of the organs of digestion, assimilation and metabolism. It must be regarded not merely as a superfluous hollow muscular organ capable simply of segregating and concentrating bile, but as an essential part of a far-flung system that is so intimately associated with one of the body's group organs, the digestive tract, that even slight disturbances of itself may have consequences out of all proportion to its apparent insignificance.

A mental diagram of this intricate and far-flung system will help us visualize the correlation of its component parts and the interdependence of each of these parts on the others for the normal behavior of the group as a whole. It will likewise focus our attention on the importance of a normal gallbladder to proper hepato-enteric function and a diseased one's tendency to completely upset an otherwise smoothly working piece of physiological mechanism. In the former instance the tiny biliary pouch occupies the role of a benign, useful, silent little organ seldom thought of and rarely heard from, while in the latter instance it becomes a constant source of trouble, making its baleful presence known by symptoms that may be a mere whisper but are frequently a lusty shout. The figurative outcry may be so persistent and resistant in certain patients as to make us wish nature had neglected to include the troublesome device in the human body economy.

In our diagram, as suggested by Rehfuß, let us visualize the liver and digestive tract as the chief component parts of a great circuit. "The two are intimately connected by two tracts, one the portal vein running from the digestive tract to the liver, and the other the biliary tract running from the liver to the digestive tract. This has been described as the "hepato-enteric system of the French." Visualize the essential mechanics involved. The efferent or portal system drains almost the entire digestive tract, or that vast area between the coronary veins of the esophagus

and the superior hemorrhoidal vein going to the rectum. Conversely, the small biliary radicals arising between the liver cells unite and increase until we have a right and left hepatic duct converging to form the biliary tract proper which conveys bile to the digestive tract. Between the liver and the duodenum on this biliary transit line appears that diverticulum called the gallbladder.

As an amplification of our mental diagram we may regard the liver as a wedge, an extremely important one, between the portal system on the one hand and the systemic circulation or inferior vena cava on the other.

The picture gives us all the essential data for constructing our knowledge of gallbladder disease. It will be seen that, from its position in the hepato-enteric system, the organ is vulnerable from four sources: 1, the liver, portal vein, digestive tract; 2, the systemic circulation—any infection or toxemia capable of infecting the gallbladder; 3, the lymphatics—liver, pancreas, duodenum; and 4, possible ascending infection from the duodenum.

It is generally agreed that gallbladder disease is the commonest cause of upper abdominal trouble. The averaged reports of numerous investigators and medical centers indicate that 24 per cent of the adult population have gall stones and that an equal number have cholecystitis without stone. This indicates clinically that nearly half our civilized adult population have disorders of the biliary tract that may at any time give rise to active symptoms. Autopsy records increase the indictment. Crump in Europe reported that postmortem statistics revealed the fact that some form of choleciostopathy was demonstrated at 60 per cent of necropsies. A specific survey not long ago at the Mayo Clinic, covering some six hundred routine postmortems, showed evidence of cholecystitis present in 66 per cent of the cases, in only eight per cent of which a primary diagnosis of cholecystitis had been made.

Be these statistics worth what they may, it is universally conceded that biliary disease is not only the most common of upper abdominal conditions but is one of the commonest causes of general ill-health and reduced physical efficiency to which our adult population is subjected. To the solution of the problem surgery has for years mobilized its forces, but the in-

ternists' attack of the problem has not been as vigorous or concerted. Only in recent years have the latter's efforts been undertaken systematically and thoroughly, and then only because of a realization that became increasingly apparent to surgeon and internist alike, namely, that in the vast majority of cases gallbladder disease is an end result, and that although the surgeon can remove the end result he cannot excise the underlying etiology involving other organs. His case is complete and is replete with brilliant results in operative management of biliary disease but, as Sir Berkley Moynihan is quoted as saying, the surgeon has realized that whereas calculous cholecystitis is his problem and is solved with satisfactory results in a large majority of cases, the results of stoneless gallbladders submitted to the same procedure are not so good.

These factors have stimulated a rationalization of surgery and increased medical efforts. For example, newer methods of diagnosis have demonstrated a large group of biliary diseases in which alterations in the tract are functional rather than organic and by no means irremediable under proper medical management. There has been demonstrated, furthermore, a group in which gallbladder disease is but a part of wide-spread general pathology incapable of relief by the simple expedient of extirpating the end result.

New light is continually being thrown on the complexity of gallbladder disease. Newer conceptions of the physiology of the organ are based on experimental surgical procedures, on improved methods of roentgenological study, and on the use of the duodenal tube. These and other expedients enable us to correlate and understand the behavior of the organ in health and disease. From many clinics have come the results of bacteriological studies. They point with increasing emphasis to certain bacterial groups and to primary foci of infection. One has but to follow current contributions to medical literature to realize the significant incidence of gallbladder disease associated with focal infections, notably of the teeth, tonsils, sinuses and bowel. It is becoming generally more apparent that no one organism is responsible for cholecystitis. It has been experimentally proved that organisms from widely different sources are capable,



under appropriate conditions, of producing cholecystitis. This may account, incidentally, for the satisfactory results reported by clinicians who have treated gallbladder disease, associated with other foci of infections, by vaccine therapy.

The physiological aspects of the normal gallbladder can be mentioned only briefly. It is a hollow, muscular organ situated as though it might have been grafted by nature onto the bile tract. Its main function would seem to be the storage of bile during the interval between meals. Its mucosa has a highly specialized function concerned essentially with the alteration of the bile stored within itself, from which it withdraws water, leaving the bile from four to ten times more concentrated than when it comes from the liver. Of particular significance is the fact that when this mucosa is acutely inflamed chronically injured, or atrophic, it loses this power of concentrating bile. Three muscle layers in the wall of the gallbladder accomplish, under normal conditions, a rhythmic and simultaneous reduction of the organ in all its dimensions. Though investigators are not in agreement as to whether its function be active or passive in character, the weight of opinion leans toward the former conclusion. Many factors suggest an explanation of gallbladder activity, among them: first, contraction of the wall, the chief stimulus for which appears to be the hormone cholecystokinin, produced in the duodenum by the action of a few substances, most effective of which are egg-yolk and cream; second, contrary innervation of the sphincter of Oddi at the ampulla of Vater. This sphincter at the junction of the common duct and the duodenum relaxes when the gall bladder contracts—contrawise, it contracts when the gallbladder fills. When the latter is removed the sphincter of Oddi usually becomes temporarily incompetent and bile dribbles into the small gut until partial competence is reestablished.

The third factor is the dilution and interchange of bile: fourth, varieties of intra-abdominal pressure. Others include the influence of the nervous system, of the gallbladder hormones, and of food. These factors have all been demonstrated experimentally. The last named, that of food, we have all seen demonstrated by x-ray. The advent of cholecystography clearly demonstrated the significance

of food in the induction of gallbladder evacuation, for a fatty meal is now universally acknowledged to induce gallbladder contraction. It is interesting to note here that proteins produce much less contractile effect, and that carbohydrates exert practically no effect whatever. It is well to remember this when we assiduously strive, as a routine procedure, to delete all fats from the diet of the unclassified cholecystitic patient.

Turning back now to our consideration of the intimate association the gallbladder assumes with the liver, portal circulation, the gastro-intestinal tract and adnexa, and the general systemic circulation, we are struck with the logic of the contention that not only is gallbladder disease itself too often an end result, but also that it is rarely the only end result. A vast amount of data presents a bewildering array of associated clinical conditions linked up with cholecystitis, such as hepatitis, pancreatitis, arthritis, myocarditis, angina pectoris, duodenitis, colitis, peptic ulcers, secondary anemias and numerous nerve involvements, most of which, unlike the gallbladder, are not amenable to surgery, much as we would like, sometimes, to surrender our persistent and intractable gallbladder cases to more drastic procedures by the surgeon, who in turn may wish occasionally to surrender a postoperative case that presents permanent and trying sequelae. Adequate study and proper classification of the gallbladder patient makes for better management and fewer sequelae in a type of sufferer that, at best, may try the patience of a Job.

For the purpose of discussing briefly and disposing of a commonly occurring involvement of the gallbladder which, of itself, is an old story, two broad categories may be established—calculous and noncalculous diseases. Of the predominantly primary disease, cholelithiasis, little need be said. Every practitioner has had intimate experience with the gallstone patient. The literature is replete with the etiology, incidence, mechanics of formation, etc., of biliary calculi. The stones are of variable nature and composition. We are familiar with their locales—intrahepatic, hepatic and cystic ducts, gallbladder, common duct and ampulla. The picture of the seizures is typical. The attack is usually acute and most likely to occur during the hours follow-

ing midnight because the evening meal is ordinarily the fullest one and more prone to contain indigestible fats. Needless to say, the pain of gallstone colic is usually sudden in onset, its position epigastric or over the gallbladder area under the rib margin on the right, and its radiation to the right shoulder blade and around the costal margin. It may be paralyzing in intensity or mild in type, but frequently so excruciatingly severe as to demand the most powerful weapon we possess, a hypodermic of morphine, for its relief. There are various sequelae, not infrequently a mild degree of jaundice and a rising level of serum bilirubin shown by the icterus index or the Van den Bergh reaction. Repeated attacks with significant sequelae become surgical problems, just as do the acute stoneless cholecystitis cases with similar aftermaths. The acute gallstone case is characterized by lusty symptoms and develops largely into a localized problem with few complexities of evaluation and management.

Not so the second category, that of gallbladder disease without stone. Chronic cholecystitis follows no sharply-defined pattern of identification as seen in the gallstone case. Though its symptomatology, in most instances, sooner or later becomes more or less characteristic, such is not always the case. Its identifying clues may be elusive, scattered and vicarious. It may even be absolutely silent. Ordinary diagnostic methods may disclose it, or it may resist identification even in the face of elaborate and concentrated effort. Its ordinary symptomatic display may follow closely that of many conditions characterized, for example, by the so-called nervous exhaustion syndrome and general ill health. All gallbladder patients are not of the "liver" type, a condition commonly postulated for diagnosis. The disease is frequently found in individuals who show no external evidence of liver disorder. The infectious type of gallbladder disease, it is true, usually produces inroads into the general health and appearance of the patient. Here, of course, we have the individual who *is* subicteric in hue and type, has a dark complexion which is normally lighter, and so-called "liver spots" on the skin of the face and abdomen. The absence of these visibly discernible changes should not blind us to the possibility of biliary disorders in individuals

who do not present them. Fortunately for us, gallbladder disease of the silent type is not often encountered; the majority display more or less characteristic signs that, properly evaluated, simplify the diagnosis of both the disease and its complications.

The cases with the commonest form of cholecystitis, the so-called low-grade infected gallbladder, display many important signs. These individuals usually fatigue easily and require more rest than do ordinary ones. They seek it during the day and prolong the nightly period of rest in bed. They describe an exhaustion rather than a fatigue. They are light sleepers and commonly awakened at two or three o'clock in the morning, no doubt because of the functional activity of the gallbladder at that period. They usually awaken unrefreshed, failing to accomplish normal restitution with sleep. They often wake with a bad taste in the mouth, a feeling of having been struck a blow across the shoulders, and various muscular aches and pains. They are notoriously constipated and cathartic addicts.

They are subject to rheumatic and arthritic phenomena especially in the morning. Though they rarely lose much weight, they may lose rapidly during an acute attack and have slow restoration. Their appetites are capricious. They discover an intolerance for certain foods, and avoid them, knowing they will precipitate an attack. They are frequently subject to food allergies. They often complain of a migraine headache which, incidentally, may be closely associated with sinus, postnasal, tonsillar and upper respiratory infection, any of which may be an etiological factor of cholecystitis.

Colon disease is a commonly associated complaint, four out of five patients evidencing a spastic constipation, underlying which may be anything from a functional spasm to an intractable sigmoiditis and colitis. Disturbance of vision is exceedingly common, such as spots before the eyes and transient diminution of vision acuity. Eyeground examinations may demonstrate vitreous opacities and choroidal changes. Half the patients complain of joint and muscle disturbances, which are readily distinguishable from gout occurring in association with liver disease. Complaints of cardiac symptoms are not uncommon. Increasing attention has recently been called to the fre-



quency with which the heart muscle is involved in gall bladder disease. The patients may describe anything from a simple palpitation to an angina, which is highly significant, as one out of four patients with angina pectoris resulting from coronary sclerosis also has chronic gallbladder disease. Conversely, removal of a diseased gallbladder may permanently relieve symptoms erroneously attributed to angina pectoris, or may alleviate the symptoms of actual angina pectoris. Nerve phenomena are prevalent in infectious gallbladder disease. The patients are inclined to be irritable, depressed, and to develop inferiority complexes. They are pessimists; they see everything through dark glasses.

But by far the most important single symptom of chronic gallbladder disease is recurrent flatulent indigestion. Particularly after a large or fat meal the victims suffer from bloating or upper abdominal distention and seek relief by belching. This is not an ordinary aerophagia. It is one of the phenomena of gallbladder disease. It may almost be declared axiomatically that, when an individual consults you complaining of bloating and distention after meals before any amount of real fermentation could take place and who seeks relief by loosening a belt or a tight garment, that individual is probably suffering from some form of gallbladder disease. It is a persistent symptom, controlled by no ordinary measures. Spastic constipation has usually developed and the sufferer has resorted to quantities of aromatics, carminatives and cathartics, which too often only enhance the digestive disturbance. Pain of variable degree and character may accompany this bloating distress and may simulate peptic ulcer, but in the latter condition the recurrence and periodicity are sharply defined. Ulcer and cholecystitis may exist concurrently, but careful diagnosis will establish their coexistence. It should be remembered that an acute, gnawing pain, recurring in type, is occasionally encountered in gallbladder disease complicated by duodenitis, and may so completely suggest peptic ulcer as to make diagnosis difficult. Of help here is the fact that fats and creams are usually well tolerated by the ulcer patient but are usually poorly borne in the case of gallbladder. The characteristic pain

of gallbladder disease is epigastric and over the organ itself. It is a common complaint, as is heartburn. Nausea is infrequent. Vomiting occurs, as a rule, only in acute attacks.

Age incidence has been widely observed in cholecystitis and needs little comment here. The condition occurs in three out of four cases in persons between thirty and sixty. The average age of patients presenting themselves is forty-two. It is, therefore, pre-eminently a disease of middle life when infectious and metabolic disturbances are likely to be ingrained. Histories indicate that the disease begins, roughly, between the thirtieth and fortieth years, though it may occasionally begin in early youth or advanced age.

It would seem apparent then that there is a gallbladder type of patient, of more or less distinct personality, and that his complaints are of a certain order. But it would seem unwarrantedly presumptive to suppose that such complaints are always due alone to a gallbladder lesion, and the fact that chronic cholecystitis is so frequently associated with disturbances of the stomach, liver, pancreas, large and small gut, heart and circulation, joint and nervous system makes consideration of the gallbladder patient so complicated.

Diagnosis of chronic gallbladder disease, as in other complex involvements, leans heavily on a thorough and carefully elicited history. Consider the time involved well spent. Careful physical examination is equally important, not directed solely to the right upper quadrant of the abdomen but to the most distant and seemingly unrelated organs and groups, any one of which may render invaluable clues. In cholecystography and the duodenal tube we have specific diagnostic devices. The use of x-ray with a contrast medium is now universally employed. Proper technique and interpretation are of great importance, and are classically described in the works of Graham and Cole, Stewart, Rehfuess, and others. The duodenal tube is to the biliary tract what gastric analysis is to the stomach and is the most logical means of study of the gall passages. It demonstrates physiology and physiopathology whereas the x-ray demonstrates anatomy. They are thus complementary to each other. A discussion here of duodenal intubation is unnecessary. We are all familiar with the simplicity of the procedure and its diagnostic

value. The repeated use of all our diagnostic expedients is often necessary in chronic gallbladder disease, but once a comprehensive diagnosis is made and the complexities understood, rational treatment can be undertaken with the assurance that relief will be much more readily accomplished than if we regard the gallbladder as an isolated unrelated organ, doomed, if diseased, to be snatched from its bed in the name of overoptimistic expediency.

The question of treatment of gallbladder disease, must, like that of diagnosis, be passed over briefly. Cholelithiasis has been mentioned. Most cases ultimately and rightly reach the surgeon, but many patients with gallstones, for reasons good and bad, are not operated on. In many cases there are valid contraindications for surgery, such as age, asthenia, circulatory disturbance, chronic infection and metabolic disease. Medical treatment cannot accomplish the engaging miracle of removing stones. The only hope is to prevent further formation by relieving the causes and abnormalities that have disposed toward their formation. Much can be accomplished, too, both subjectively and objectively, by the management of diet, control of infections, relief of stasis, use of the duodenal tube, use of medication for symptomatic relief, regulation of the colon, vaccines, and careful periodic recheck of the patient.

The treatment of stoneless gallbladder disease has its success predicated largely on a complete diagnosis of all the factors involved.

The infectious type may be the result of a focus at some far distant point, and the foci must be discovered and removed. Secondary involvement of the gallbladder by organisms may be treated by vaccine therapy, filtrate therapy, nonspecific therapy and systemic measures. Streptococcus, staphylococcus aureus, and bacillus coli are the commonly found bacteria. Systemic measures are fundamental here as in the treatment of all chronic infections, and include rest, fresh air, sunshine, sensible diet, the use of vitamin A, etc.

The stasis type is treated by diet, exercise, drug therapy, duodenal intubation, diathermy, and the same systemic measures noted above. In the general medical management of non-infectious gallbladder disease, certain drugs and duodenal intubation constitute the chief local therapeutic measures. The drugs in com-

mon use are sodium sulphate (Glauber's salt), magnesium sulphate and the so-called "bile salts." The salines probably exert most of their effect on the gastro-intestinal tract and serve as detoxicants rather than as bile eliminants unless we consider the reflex action of the sulphates of magnesium and sodium when introduced by intubation directly to the ampulla. Of the so-called "bile salts" only one, decholin sodium, would seem to be specifically effective. It is the only one that can be used with safety intravenously. Decholin is essentially a choleretic drug. It increases the amount of bile through stimulation of the liver cell, and is infinitely less toxic than the other bile salts.

Treatment by duodenal intubation may be undertaken as a simple drainage; as a drainage with stimulants such as magnesium or sodium sulphate, peptone, olive oil, oleic acid, or dilute hydrochloric acid; as a means for the injection of disinfectants; for the Einhorn feeding method; for continuous aspiration; etc. The individual case determines the detail of procedure. Tubal drainage should not be undertaken in acute cases, in patients recovering from an attack, or in asthenias and cases complicated by wasting diseases. The process is dehydrating and debilitating. Its chief usefulness is in the chronic cases wherein the patients have maintained weight and have not reached the stage of a general functional breakdown. Furthermore, its use in gallstone cases in which surgery has been interdicted is frequently followed by beneficial results.

Diathermy may be used as a therapeutic agent for the chronic gallbladder. It should be carried only to the point where the patient feels a comfortable sense of warmth.

The use of any or all of the expedients mentioned presupposes careful evaluation and proper management of the various concurrent disorders, symptomatic vagaries and sequelae of the biliary disease itself.

As a summary of our efforts directed toward gallbladder disease we may recapitulate the steps briefly:

1. Careful diagnosis: history, physical examination, duodenal intubation, cholecystography, general diagnostic survey.
2. Decision as to medical or surgical treatment.



3. Medical treatment: Alteration of general hygiene, dietary regime, medication, regulation of bowels, duodenal intubation, vaccine therapy, removal of focal infection, physiotherapy.

4. Periodic recheck of patient.

These steps, undertaken with precision and exactness, may help us in our management of the plaguing problem of medical practice, gallbladder disease.

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## CAUTERIZATION OF THE CERVIX UTERI

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The electric cautery was first used by Byrne in 1892 in treating cancer of the cervix. Hunner experimented with the Paquelin cautery in 1906 in treatment of chronic endocervicitis. Dickinson began using the nasal type cautery in treatment of chronic endocervicitis in 1911 and recommended it to the medical profession in 1921. This is the method that is now commonly used with various modifications. There have been several other methods used for cauterization of the cervix, namely: chemical cauterization, radium, and various forms of electro-coagulation. It is not the purpose of this paper to compare these various types of cauterization. While cauterization of the cervix by means of the electric cautery does not give the entire answer to treatment of diseased cervixes it seems to me that in the majority of cases of endocervicitis it has proved itself to be the most valuable agent that the average physician can use.

In order to intelligently discuss cauterization of the cervix it is essential that we review the histology of the normal cervix and pathology of the diseased cervix. Briefly, the cervical canal is made up of a lining mucous membrane which is marked by longitudinal and oblique ridges. The mucous membrane is composed of columnar epithelium lining the complex racemose glands in this portion of the cervix. Simple squamous epithelium covers the vaginal portion or "face" of the cervix. Beneath this lining membrane lies

smooth muscle and fibrous tissue making up the body of the cervix. The cervix is especially rich in blood vessels and lymphatics. Except in deep lacerations and cancer of the cervix our primary consideration in treatment of the diseased cervix is the lining mucous membrane.

Diseases of the cervix may vary from a simple erosion to carcinoma of the cervix. In cervicitis infection is primarily in the deep racemose glands of the cervical canal accompanied by a mucopurulent discharge. Whether this discharge destroys the squamous type epithelium on the "face" of the cervix or whether this epithelium is destroyed by the original inciting agent such as childbirth or instrumentation is a matter of controversy. At any rate there is a growth of columnar epithelium onto the "face" of the cervix replacing the normal epithelium and forming the so-called erosion. In cervicitis the tissues are found to be edematous with some round cell infiltration. In cases of endocervicitis following lacerations there is usually an eversion of the cervical canal giving that red pouting appearance to the cervix. The deep glands lining these tears become infected. The backache, which is the most common symptom other than the discharge, has been ascribed to involvement of the glands draining the cervix which lie along the retroperitoneal space in the lumbosacral region.

Acute cervical conditions such as caused by gonorrhea should never be cauterized until the acute condition has cleared up and there is a certainty of no adnexal involvement. Where there is doubt a white blood count and temperature reading should not be overlooked. In cases where there is a marked retroversion of the uterus cauterization should not be done unless there is a well established drainage from the cervical canal and a freely movable uterus. This is especially true where there is a marked congestion of the pelvic organs and usually associated with it is an edematous cervix. In early cases of pregnancy cauterization may be done lightly probably without any harm but I believe most cases are best left alone during pregnancy. Certain diseases such as diabetes are contraindications to cauterization of the cervix until the disease can be controlled.

Technique of cauterization. One of the most important steps in cauterization after your contraindications have been ruled out is the time in the menstrual cycle when the cauterization is done. The optimum time is one to two days following a normal period. The reasons for this are that no matter how lightly the cauterization is done it is essentially a burn and such wounds, as we all know, take longer to heal than a simple incision. Healing is delayed because the wound is more or less enclosed and constantly wet. At this time there is usually less danger of hemorrhage because there is less pelvic congestion. The wound has as much time as possible to get well before the next cycle starts.

I cauterize my patients routinely as an office procedure without any anesthetic unless there is some complication. It is wise to tell them that they may have some slight pain but also assure them that if the pain becomes too severe that the procedure can be stopped at any time continuing in a few minutes after the patient has calmed down. This should be carried out in practice as well as theory. After the patient is put in the lithotomy position it is good practice to check up on the position of the uterus and condition of the tubes and ovaries even though this has been done a few days before. Next the bivalve vaginal speculum is inserted and the cervix carefully inspected. If there is any suspicion of active gonorrhea a smear should be made and studied before cauterization. Usually there is a plug of mucus in the cervical canal which should be cleansed away and, incidentally, caroid powders applied in the cervical canal are usually efficacious in removing this mucus. The cervix is then thoroughly dried, including as much of the cervical canal as possible. This is important because part of the pain of which the patient may complain, especially abdominal cramps, is possibly due to steam escaping through the tubes and, too, if the area is too damp there will be very little cauterization of the tissues. Of course there will be some steam at the best but it should be made the minimum. If there is any doubt in the physician's mind as to whether the patient may have a cancer, a biopsy should be taken at this time with biopsy forceps. The biopsy site may be cauterized to control the bleeding but nothing else should be done until a report is obtained on the biopsy.

Following this, a probe should be passed beyond the internal os to see that there is no stenosis of the cervical canal and I feel, as Doctor Hoffmann of Orlando has already described in a previous paper, that the cervical canal should be gently dilated at least the size of the standard uterine dressing forcep primarily because this will usually prevent a stenosis following cauterization.

There is a great temptation to cauterize the "face" of the cervix with only a passing touch to the cervical canal but herein lies a good many failures of cauterization. It must be remembered that the pathology is primarily in the racemose glands of the cervical canal. For this reason the cervical canal should be cauterized first. A simple postcautery is used with small nasal tip about  $1\frac{1}{2}$  inches long. This cautery has a finger switch which may be turned on or off at will. The cold cautery tip is inserted into the prepared cervical canal just short of the internal os. Care should be taken not to let the cautery touch the vaginal canal during cauterization. The switch is then turned on and the tip pressed firmly to the side of the cervical canal and quickly rotated until the entire surface of the canal has been treated. How long the cautery should be kept in the cervical canal it is hard to say; experience usually tells you when to stop. Usually a faint sizzling sound is heard and a white discoloration appears on the external os next to the cautery blade. This is only a few seconds in time. It is always better to under-treat than to over-treat.

After the cervical canal has been treated the "face" of the cervix should be attended to. Personally, I have never been able to get the results I wish from the so-called "striate" method of cauterization as I feel that I cauterize too deeply, using that method with a resulting excess scar formation. I prefer to use what might be called the "punctate" method, applying the tip of the cautery at various points around the circumference of the cervix, cauterizing to the extent that I obtain a white to yellowish-brown cauterized area. These areas should slightly overlap each other. When there are nabothian cysts they should be charred completely and also wherever there is surface oozing blood.

Cauterization may be stopped at any time that the physician or patient desires. Cauterization can usually be done at one sitting with-



out any great inconvenience to the patient except those cases of extensive laceration with distorted cervixes. In cases where there are tears into the body of the cervix a good many may be improved if not totally repaired by cauterizing the old torn surface thoroughly.

After the cauterization is completed the patient is told to take a saline douche daily, beginning two days following the cauterization, for cleanliness only. It is well to caution her not to insert the douche nozzle too far and to refrain from intercourse until after the next period. She is also warned particularly if there has been any deep cauterization that she may have some bleeding six to twelve days following the cauterization at which time the cauterized area may be expected to slough off. If there is too much bleeding at that time she should report to the office for it may be necessary to cauterize a small bleeder or even pack the cervix. She is also told to be careful during her next period and if she has very much pain or an excessive flow or greatly diminished flow with pain to report following that period or if necessary during the period. Finally the patient is told to return following her second menstruation from the date of the cauterization for a check-up and usually the patient is never seen until that time. At the time of the check-up the cervix is probed for any stenosis. If this should be found the cervix should be gently dilated. However, if the cauterization is not too deep this will be rarely found. If there are any areas which are apparently not healed they should be re-cauterized at this time. In cases of severe cervicitis a second cauterization is almost always needed but rarely a third unless there is a reinfection or some other trouble developing later. She is, of course, warned that her discharge will be worse for a while and that her symptoms such as pain in the back, etc., will not be relieved immediately but will gradually subside.

It seems to be the custom for each woman to be told to check in at six to eight weeks for an examination following childbirth and a good many physicians cauterize the cervix at that time, if needed, feeling that since involution is not complete the cauterized area will heal quicker. If there are any lacerations of the cervix or any raw bleeding areas on the cervix at six to eight weeks postpartum

they should be cauterized at this time but since involution is not complete at six to eight weeks it seems to me preferable to wait until the fourth or even sixth month following delivery. Meanwhile the patient should be put on a simple cleansing douche. By waiting there is always a smaller area to be cauterized with less resulting scar tissue.

It is well to emphasize in closing the discussion of the technique of cauterization that one cannot be too careful in the examination of the patient previous to the cauterization for a good many of the complications following cauterization lie just here. Doctor Dell, Jr., of Gainesville, read an excellent paper before this body last year on complications following cauterization. It is also well to emphasize that it is better to under-treat than over-treat cervical lesions bearing in mind that they should be followed up until cured.

When we know that 75 to 85 per cent of all women have cervical lesions and when we realize that this is the most frequent site of cancer in women usually beginning on one of these lesions, let me urge a more complete examination of women patients and a more complete follow-up of obstetrical cases and treatment when needed. At least 40 per cent of all women who have borne children need treatment of the cervix following the delivery.

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## BLACK WIDOW SPIDER BITES

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My attention was directed to this type of poisoning by two cases which I had occasion to treat during the summer of 1937. I wish to report these cases briefly and to give some of the most important observations on the black widow spider bite, which Bogen<sup>1</sup> contends is a "true clinical entity in the field of general medicine." Most of my information will be taken from recent literature as the textbooks devote limited space to this rather common condition.

Perhaps the *Latrodectus mactans* or black widow spider is the only poisonous spider inhabiting the United States. This opinion is contrary to the general belief of the laity and some physicians. The local pain, redness, swelling, discomfort and at times suppuration and sloughing of the skin which follows the common spider bite are caused by pathologic organisms injected into the puncture wound and not to the injection of a true poison. This specific spider derives its name, black widow, from the fact that as soon as her eggs are fertilized she attacks her mate, kills him and sucks out his tissue juices. The adult female alone is responsible for all human bites.

Viewed from the dorsal side, her body is composed of a minute head, a somewhat larger cephalothorax and a large oval abdomen measuring about  $\frac{1}{2}$  inch wide, and has a leg spread of from  $1\frac{1}{2}$  to 2 inches. The body is so shiny black that it gives the appearance of a metallic lustre. On the ventral surface of the globoid abdomen there is a bright red or yellow marking in the shape of an hour-glass. This is the most constant marking but additional red or yellow stripes are often found on the ventral surface and at times on the dorsum. Due to the large oval abdomen this species has also been referred to as the "shoe-button spider."<sup>2</sup> The *Latrodectus hasseltii*, or red back spider, found in the Philippine and neighboring islands, is much smaller, very poisonous and its bite causes a similar train of symptoms as those about to be described.<sup>3</sup>

## CASE REPORTS

CASE 1. Mrs. E. C., aged 26, was a white female weighing about 110 pounds. I was called to see her about 9 o'clock on the night of May 23, 1937, at her home six miles from Quincy. Before getting out of my car I could hear the patient groaning and screaming at intervals. She was lying in bed on her left side with knees and thighs flexed and the hands holding her abdomen. The history was as follows: about 7 p. m., while sitting on an outdoor privy she felt a sharp stinging sensation on her buttock but thought very little of it. About thirty minutes later she began having cramping pains in her lower abdomen and was given an enema with no relief. The pains grew steadily worse, gradually extending to her legs, chest and arms in the order named. She was nauseated but did not vomit. She described it as "I am hurting all over but it's worse in my stomach." Examination showed she was acutely ill, with profuse cold perspiration, rapid, shallow and somewhat jerky respirations. The pulse was slow and rather thready; the temperature was normal; heart sounds were distant. On palpation the abdomen was almost board-like. There seemed to be a generalized tenderness but no point tenderness could be elicited. On the right buttock there was a small red area about the size of a quarter.

She was given morphine grains  $\frac{1}{4}$  and put in a hot sitz bath from which she obtained some relief from the pain only to have it return in 10 minutes after being put back to bed. She was then given 10 cubic centimeters of 25 per cent magnesium sulfate intravenously and was almost instantly relieved. In about one hour she began complaining again and was given another  $\frac{1}{4}$  grain morphine. She was restless all night and at 4 a. m. phenobarbital, grains  $1\frac{1}{2}$ , was administered by mouth.

The following day the abdominal, back and leg muscles were sore and there was still some abdominal discomfort which did not require an opiate. The patient made an uneventful recovery after three days in bed with only barbiturates for pain and restlessness.

The husband was asked to inspect the privy and the next morning he found a large black widow with the characteristic coarse, irregularly woven web across the seat of the toilet.

CASE 2. W. T., a well-developed and nourished, rather muscular, colored male, aged 29, came to my office at 10:15 a. m. on July 30, 1937. He was complaining of severe cramping pains in the abdomen, chest and back. He was holding his abdomen with both hands and would not sit or lie down but walked the floor and begged for relief from the pain. On questioning he stated that something bit him on the penis while sitting on an outdoor privy about 8 a. m. Twenty minutes later he began having pains in his left hip and leg, but he went on to his work in a tobacco warehouse. About an hour later he was having cramping pains in his abdomen, which gradually grew worse and spread to the chest and back muscles until he had to stop work and seek relief. He was nauseated but had not vomited. The physical examination was essentially negative except for the abdomen which was very rigid with generalized soreness but no localized tenderness. The foreskin was slightly edematous but there was no visible wound or redness of the skin. Temperature was 98.2/5, pulse 66, blood pressure 110/75. The pulse was slow but with a good volume.

He was given 10 cubic centimeters of 25 per cent magnesium sulfate intravenously with almost instantaneous relief which lasted only 10 minutes. He was then given nitroglycerin grains  $\frac{1}{100}$  under the tongue with no effect on the symptoms which patient stated were growing worse.

A spinal puncture was done and 10 cc. of clear fluid removed with immediate relief. He was completely free of pain for about 20 minutes after which it returned but with less severity. He was given dilaudid grains  $\frac{1}{16}$  and sent home. About five hours later an-

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other opiate had to be administered. He remained in bed the next day but was able to return to work the following day.

The privy was inspected and one of the shiny little black spiders with the red belly was captured.

Some few experimental bites have been reported so that the writers could give a personal subjective account of the symptoms. I will quote from Blair's experiment.<sup>4</sup>

10:45 a. m. The spider bit the moment it came in contact with the skin surface and was permitted to bite for ten seconds. The sensation resembled that of the prick of a very sharp needle, accompanied, however, by a burning sensation which increased in intensity during the biting period.

*1st Stage:* Lymphatic absorption, 10:52 a. m. The area of blanching was more marked; the entire terminal phalanx was reddened; there was a throbbing, lancinating pain in the bitten finger. 11:07 a. m. Pains in the axillary region now commanded more notice than the throbbing, occasionally lancinating pain in the finger.

*2nd Stage:* Vascular dissemination. There was a dull, aching, drowsy, lethargic feeling. Slight transient aching pains were noted in the epigastrium. 12:00 a. m. Aching pains in the neck; a feeling of general malaise; blood pressure 108/82. The pulse was weak and its rate 62. (From this stage on, notes were made by assistant). 12:30. Severe, aching pain was present in the lumbar region, abdomen, and chest, with a feeling of constriction in the latter. Speech was difficult and jerky; respirations were rapid and labored; the abdomen was rigid; heart sounds were slow, regular and normal in character; the pulse was weak and thready. 12:50 The patient was unable to stand, showing almost rigid flexion of the legs, extreme ashy pallor and cold clammy sweat. He was put in a hot bath; he stated that he experienced an immediate, appreciable diminution of pain and a sense of general relief.

*3rd Stage:* Elimination. 2:05 p. m. The patient stated he felt a little better. White blood cells, 13,200; polys 79; lymphocytes 20, and monocytes 1. He was given morphine grains  $\frac{1}{4}$ .

From the report the patient had a very restless, sleepless night. The following day the temperature was 2 degrees above normal and the white blood cells went to 19,000. He had generalized soreness in abdomen and back with rheumatoid pains in the legs and feet. The urinary output was markedly diminished for three days. After the third day he made rapid improvement. The treatment consisted only of hot baths, morphia ( $2\frac{1}{4}$  gr. doses), barbital with amidopyrine and magnesium sulfate.

From the observations of Blair, which have been supported by others, he seems to be justified by his conclusions that the clinical picture has three distinct stages, namely: lymphatic absorption, vascular dissemination, and elimination. The symptoms usually begin thirty minutes to two hours after the bite. By this time the pain and discomfort at the site of bite have usually subsided and the patient may not connect the later symptoms with the in-

itial bite. The dissemination of the pain differs somewhat according to the location of the bite. When the bite occurs on the penis, scrotum, or buttock the ensuing pains are more pronounced in the lower abdomen and thighs and the nausea and vomiting are worse. When the bite occurs on the upper extremity or head the pains in the chest attract the most concern with a severe headache, the nausea and vomiting being slight or absent. However, in any location, there are cramps in the abdomen with a board-like rigidity of the abdominal muscles. The other outstanding symptoms are the rapid, shallow, often jerky respirations, profuse cold perspiration, profound shock, slow, thready pulse, slight elevation of temperature, polymorphonuclear leukocytosis, and a facies exhibiting excruciating pain and apprehension. The following are also encountered less frequently: cyanosis, delirium, insomnia, speech disturbances, acute urinary retention, tremors, twitching, paralysis, convulsions, chills, dizziness, priapism and jaundice.

The poison of the *Lactrodectus mactans* is a clear, white viscid substance, containing a highly neurotoxic venom. In the second stage the clinical symptoms, as have been described, are not unlike those of rattlesnake poisoning. However, due to the marked affinity the spider venom has for the nervous system the clinical picture more nearly resembles that produced by the bite of the South American cobra.<sup>5</sup>

The diagnosis is simple provided the physician is familiar with the more common symptoms and if he is given a history of spider bite. If for any reason there is no mention of a spider bite, then the diagnosis becomes quite confusing. The pains in the abdomen, rigid abdominal muscles, nausea, vomiting and leukocytosis are classical symptoms of the so-called "acute abdomen," including: ruptured peptic ulcer, acute pancreatitis, ruptured appendix with generalized peritonitis, and ruptured ectopic pregnancy. Also to be considered are renal and biliary colic which closely resemble spider poisoning but can easily be ruled out by a careful history. Other conditions to be differentiated are tabetic crisis, coronary occlusion, food poisoning, and lobar pneumonia.

The mortality rate is very low, some authors



reporting 2 or 3 per cent but the average would seem to range from no fatalities to one-half per cent. Though the mortality rate is very low the acute excruciating pain demands immediate treatment. Large doses of morphine are required for relief. In my two cases magnesium sulfate intravenously gave fair results, relieving instantly, only for the pain to return in about twenty minutes. Spinal puncture has been advocated. In 1935, Gilbert and Steward stated that they had good results with calcium salts intravenously. Drake<sup>6</sup> in 1937 confirmed this report using calcium chloride intravenously. However, one or two doses of an opiate are required.

There are no indications for stimulants such as strychnine, caffeine, adrenalin or alcohol; these drugs seem to be definitely contraindicated. Fluids should be given freely. After the more acute symptoms begin to subside some barbiturate should be given for the restlessness. The patient should remain at absolute rest in bed for twenty-four to forty-eight hours as symptoms demand.

#### CONCLUSIONS

(1) Black widow spider bite is a rather common disease entity throughout the Southern States.

(2) The mortality rate is low but the patient demands immediate and adequate treatment.

(3) A careful history would eliminate the danger of confusing the condition with an "acute surgical abdomen," and submitting the patient to an unnecessary operation.

(4) The public in general and children in particular should be taught how to recognize this spider and should be warned of its poisonous nature.

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## COMMON SENSE MEDICINE

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Palatka

The practice of "common sense medicine" is the practice of medicine by a Medical Doctor who can think and act intelligently for himself in all cases, be it an acute or chronic condition, for the betterment of the patient. He doesn't necessarily have to be a graduate of the best medical college in the country, nor to have behind him three or five years of hospital experience, though this would be in his favor.

After several thousand years, we still agree that medicine is an art, thus the art of the practice of medicine, plus the science we apply, makes up what I term common sense medicine. We, in the general practice of our art, are called on to make quick diagnoses, quick decisions and act quickly, usually without the aid of a laboratory or consultants. Therefore, it is imperative that we use common sense along with our scientific sense.

When I first began practicing medicine in the country, it was 30 miles from a hospital or fellow Medical Doctor. I shall never forget those first months, my brain crammed with symptoms of brain tumors, ectopic pregnancies, mesenteric thromboses, pulmonary infarcts, blood dyscrasias, infantile paralysis, and other rare conditions. I expected these to crop up every day and in almost every case.

Hambone says "You can go wrong by going in the right direction too fuh." The Medical Doctor today is turned out from the finest and best medical colleges with the most voluminous book knowledge and didactic training of any time in the history of medicine. I remember certain members of my class in medical school who could tell you the number of the page in Cunningham's *Anatomy* where the arm, leg or head was described but in the clinics, doing practical or applied medicine and surgery, they were at a loss as to what to do or how to treat the actual patient. I also recall in medical school that I spent hours upon hours looking through a microscope at cross-sections of a pig embryo and transferring these visual cross-sections to paper in

Read before the Second Annual Meeting of the Northeast Medical District, Ponte Vedra, September 15, 1938.

such a manner as to make a picture of that pig embryo, in the longitudinal form. Perhaps I am wrong; perhaps I didn't apply myself properly, but to this day, eight years after taking that course, I have never been able to apply any part of that lesson learned except to hate the sight of pigs. Had this time been spent in clinics or hospital wards, observing or dressing even old leg ulcers, minor wounds, etc., our common sense would have, I believe, picked up many valuable jewels of thought and experience, which would be beneficial from the beginning of the practice of medicine.

We, in America, have practiced a fairly high standard of medicine and in doing so have decreased morbidity and mortality to a lower degree than any other civilized nation on earth; yet, every once in a while it is noted that certain medical or surgical bungles occur by following classical textbook instructions and forgetting clinical experience and/or common sense.

There are more advisors to the doctor today who have never studied medicine than there are who have studied and graduated in the subject. We find the druggist, the detail drug salesman, the nurses, the county welfare agents, the man who takes a fancy to reading medical books, etc. I can see no reason for drug house salesmen coming into a doctor's office every six weeks to two months lauding his wares and telling him how to treat his patients. We get circular upon circular on the drugs and their qualities and we should know what is good and what isn't. If a house sent around its detail man once or twice a year, that should be sufficient. So many listen to the panacea which the salesman pictures of his wares, and try them at the expense and sometimes to the detriment of the patient. Is it common sense to sit and listen and tell him you will use his brand? *Aequenemetas*, Osler's great book, to me is almost like a Bible. That great man—made great not by medicine, not by books, but by good common sense. He went at his problems and handled them so easily.

Caution, care and careful deliberation are characteristics that are so greatly needed in this day of rapid changes, new methods, new

drugs and new ideas. The man who said "be not the first to try the new, nor the last to give up the old" must have been a doctor, for it applies so aptly to our profession.

#### COMMON SENSE MEDICINE IN DEALING WITH OUR COLLEAGUES

Give aid, when possible; encourage him; let him know that he can rely on you in time of need; conduct yourself, your thoughts, your actions, so that jealousy, suspicion and underhanded detrimental remarks will never appear.

Gentlemen, we live just so many years. Why not live these years in happiness, good fellowship and well meaning toward each other? It creates a good feeling to pass your colleague on the streets and elsewhere and give him a warm greeting of true comradeship. We would be very poor doctors and very poor personalities if differences, arguments and discussions, did not arise as to diagnoses and treatments; so rightly they should come up. It makes us keener, more alert and stimulates study, and a desire for more knowledge. Tolerance, broadmindedness and a sincere desire to do the right thing and help our patient will lead to an amicable understanding and a continued friendship. When we speak slightly about our fellow doctor to a patient, we injure our profession and ourselves much more than the person spoken of.

#### COMMON SENSE MEDICINE WITH THE PATIENT

A patient seeks the doctor because he is ill, either mentally or physically, or both. The present-day physician is the father confessor, family advisor, and serves as a minister, priest, rabbi and physician. We have achieved heights never before attained by our profession. Let us keep these heights and the respect of our people. Remember that meekness, the desire to do good, the untiring service to those in need, be they rich or poor, is the reason we hold the position we do today.

Our patients trust our judgment and have confidence in our advice. I have noted that we sometimes, thoughtlessly, advise a great many needless tests, examinations and treatments, not taking time to think about the uselessness of them, or the expense to the patient. Is it not common sense for us to consider these matters also? Medicine is still an art; let

us use our clinical experience and teachings; let us use our hands, our eyes, ears, the senses that God gave us, before we subject the patient to so many laboratory tests, x-ray examinations, and other expensive procedures. It is well to have these facilities at hand in case we need them, but don't depend so much on the laboratory, x-ray, electrocardiograph, metabolimeter, etc., for a diagnosis. If you do, and the trouble is finally located or ruled out, the patient is financially sick abed.

Again let us use common sense in prescribing for the patient. Numerous and costly prescriptions have caused many a patient to seek quacks, cultists, or to suffer their ailments because they knew that after the professional fee, there would be a \$2.00 or \$3.00 prescription bill to pay before relief was obtained.

We all know that the drug houses are out to sell drugs. They remind me of the automobile industry — selling the same product, but putting on new styles, body types, a slight change here or there. So it is with the drug house, selling the same drug, mixed in a different form, color or solution and lauded as another cure-all. Prescription after prescription is written for these drugs and others rarely used, and the druggist is taxed to the utmost to keep up a stock of drugs to satisfy our every whim. If we stop to think we know that there are only a few essential drugs.

Therapeutics teaches us, experience teaches us, that we can get along well with a few well-chosen, well-known and adequately tested drugs. Why not compound your own prescription as often as possible? Then you know exactly what the patient is getting. Sometimes I get the idea that some of us are grabbing for that magic cure-all prescription, that unknown Rx, that "National Remedy for Health, Wealth and Happiness" wrapped up in a bottle.

There are less than fifty essential and useful drugs on the market, yet there are thousands of remedies. How can you expect the druggist to keep so many remedies without a high overhead expense? In turn, he must make the patient pay for this overhead to keep his books out of the red.

Gentlemen, let us thank God that we are living in a country, this United States of America, where a high degree of common sense medicine has been and is being practiced, where we have the finest, largest and best equipped hospitals, the best trained medical men and women and, most important of all—because of common sense medicine, the lowest morbidity and mortality rates of any civilized nation in the world. This should be a cheering note, not only for the medical profession, but a cheering note and comforting feeling for our patients.

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**ORGANIZED PAYMENTS FOR  
MEDICAL SERVICES**

It would stretch the imagination of a social planner to devise any scheme for the organized payment for medical services that is not described in this publication of the Bureau of Medical Economics of the American Medical Association on *Organized Payments for Medical Services*. Several hundred plans for medical care of the indigent involving governmental support and medical society management are explained. Social Security legislation has brought about changes in medical arrangements reaching into almost every locality in the United States and affecting health departments, medical societies, and state and local governments. Types of plans proposed by the Farm Security Administration to provide medical services to Administration clients in 127 counties and covering 100,000 low income families are described. Medical societies have organized postpayment and prepayment plans of medical care offering a wide selection of types. Some provide for a cash indemnity to be paid to the insured with which he can purchase his own medical service and others provide medical service directly.

Industries, unions, fraternal organizations, and all sorts of mutual societies provide medi-

cal benefits for their members by a variety of prepayment devices. Some 3,000,000 persons are covered by group hospitalization plans, which show a wide variety of relations with state and county medical societies. Commercial insurance companies, all of whom pay benefits in cash, are also entering this field on a large scale. It is estimated that approximately \$300,000,000 in cash is paid out annually by insurance companies to assist in paying medical bills.

The House of Delegates of the American Medical Association has endorsed cash indemnity prepayment plans, but has not sought to prohibit any of its component societies from cooperating with or organizing other types of prepayment for medical service provided their character is not such as to render it impossible to give good medical service.

The number and variety of the plans for medical services—operating and proposed, postpayment and prepayment, service and cash, medical society and other organization sponsored—give proof of the efforts that are being made to supplement the private practice of medicine and indicate a desire to discover, by social experimentation, a solution of local medical problems.

The material for *Organized Payments for Medical Services* is largely a report of the practical work of state and county medical societies. The Bureau of Medical Economics has assembled this material for the information of all medical societies and the general public.

The booklet, *Organized Payments for Medical Services*, was prepared by the Bureau of Medical Economics of the American Medical Association. The price is 50c for a single copy and it may be secured by applying to the A. M. A.

**FACTUAL DATA ON MEDICAL  
ECONOMICS**

*Factual Data on Medical Economics*, a booklet prepared by the Bureau of Medical Economics of the American Medical Association, is an arsenal of absolutely reliable information of the sort that today is so much needed both by the profession and the public.

The price is 50c for a single copy and it may be secured by applying to the A. M. A.



## FLORIDA FOOD, DRUG AND COSMETIC ACT

This 1939 Florida act, Chapter 19656, No. 661, definitely affects the practitioner of medicine in that his official prescription is required before a purchaser can obtain certain drugs named in the act. The Florida law, together with the present Federal Food, Drug and Cosmetic Act, should overcome many abuses in the dispensing and sale of certain dangerous drugs.

In section 15, it is stated that a drug or device shall be deemed as misbranded:

(j). If it is dangerous to health when used in the dosage, or with the frequency or duration prescribed, recommended, or suggested in the labeling thereof;

(k). If it is a drug sold at retail for use by man, and contains any quantity of aminopyrine, barbituric acid, cinchophen, dinitrophenol, or sulfanilamide; unless it is sold on a written prescription signed by a member of the medical, dental or veterinary profession who is licensed by law to administer such drug, and its label bears the name and place of business of the seller, the serial number and date of such prescription, and the name of such member of the medical, dental or veterinary profession.

The purpose of this section is to control the sale of the drugs named. Heretofore, physicians sometimes advised a patient to purchase a certain number of barbital tablets, nembutal capsules or allonal tablets. Under this new act, it will be necessary for the attending physician to write a complete prescription before the druggist is legally authorized to make the sale. The adherence to the provisions of this act will prevent counter prescribing by druggists in connection with the retail sale for use by man of aminopyrine, barbituric acid, cinchophen, dinitrophenol or sulfanilamide, unless sold on a written prescription signed by a licensed member of the medical, dental or veterinary profession.

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## JOURNAL INDEX REVEALS VAST SCOPE OF A. M. A. ACTIVITIES

Some conception of the vast scope of the work of the American Medical Association is contained in the semi-annual Index Number (June 24) of the Association's *Journal*, an editorial in that issue points out, saying that:

"It is recommended particularly that readers consult page 2644 of the index under the heading 'American Medical Association.' A survey of the material listed will indicate the vast scope of the activities of the Association

at this time. It is in a sense a review of the work for the first six months of the year.

"Few people realize the information to be derived merely from turning the pages of an index one by one. For example, the relative amounts of material on page 2646 concerned with anaphylaxis and allergy and with androgens indicate the extraordinary development of interest in the latter subject during the period covered by this volume.

"No other medical periodical provides in a six months period the amount of information available through *The Journal of the American Medical Association*. It is with pardonable pride that we assert that the physician who wants to keep abreast of the scientific, political, economic, social, literary or any other phase of medicine can do so by consistent, thorough reading of this publication."

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## RELIEF OF PAIN OF CHILDBIRTH

Hope of still better methods for the relief of pain of childbirth is found in the enthusiasm and great interest of the medical profession in this problem, *The Journal of the American Medical Association* for June 24 declares in an editorial.

"Ideal methods for relief of pain of childbirth have been the goal of obstetricians since ancient times," the editorial says. "Inscriptions and drawings left by early Egyptians indicate that they tried unsuccessfully. Less than a century has elapsed since Sir James Y. Simpson of Edinburgh first used an anesthetic, a few drops of chloroform, for this purpose."

After discussing the various methods of producing obstetric amnesia (temporary loss of memory) and analgesia (absence of sensibility to pain) and certain objections that have been offered to their use, the editorial says:

"The ideal drug or combination of drugs has not yet been discovered. Perhaps in the hands of masters all of the methods mentioned are essentially safe for both mother and baby. The skilled obstetrician, at least, has the opportunity to choose the particular technique best suited to each case. The enthusiasm and great interest in this problem offer hope of still better methods."



# REPORT OF FLORIDA DELEGATES TO AMERICAN MEDICAL ASSO- CIATION HOUSE OF DELEGATES

Meredith Mallory, M. D., Orlando  
Herbert L. Bryans, M. D., Pensacola

*To the Members of the Executive Committee,  
in Session at Ponte Vedra, June 21, 1939:*

Both of your Florida delegates attended every session of the A. M. A. House of Delegates, held at St. Louis, May 15-19, 1939. The convention was very well attended, there being 7,412 present. The scientific exhibits were most instructive and were visited by many.

The most important business that was transacted was done by the special committee appointed to consider the Wagner Health Bill. The conclusions reached are as follows:

1. The Wagner Health Bill does not recognize either the spirit or the text of the resolutions adopted by the House of Delegates of the American Medical Association in September 1938.
2. The House of Delegates cannot approve the methods by which the objectives of the National Health Program are to be obtained.
3. The Wagner Health Bill does not safeguard in any way the continued existence of the private practitioners who have always brought to the people the benefits of scientific research and treatment.
4. The Wagner Health Bill does not provide for the use of the thousands of vacant beds now available in hundreds of church and community general hospitals.
5. This Bill proposes to make federal aid for medical care the rule rather than the exception.
6. The Wagner Health Bill does not recognize the need for suitable food, sanitary housing and the improvement of other environmental conditions necessary to the continuous prevention of disease.
7. The Wagner Health Bill insidiously promotes the development of a complete system of tax supported governmental medical care.
8. While the Wagner Health Bill provides compensation for loss of wages during illness, it also proposes to provide complete medical service in addition to such compensation.
9. The Wagner Health Bill provides for supreme federal control: federal agents are given the authority to disapprove plans proposed by the individual states.
10. The Wagner Health Bill prescribes no method for determining the nature and extent of the needs for preventive and other medical services for which it proposes allotments of funds.
11. The Wagner Health Bill is inconsistent with the fundamental principles of medical care established by scientific medical experience and is therefore contrary to the best interests of the American people.
12. The fortunate health conditions which prevail in the United States cannot be disassociated from the prevailing standards and methods of medical practice.
13. No other profession and no other group have done more for the improvement of public health, the prevention of disease and the care of the sick than have the medical profession and the American Medical Association.
14. The American Medical Association would fail in its public trust if it neglected to express itself unmistakably and emphatically regarding any threat to the national health and well being. It must, therefore, speaking with professional competence, oppose the Wagner Health Bill.
15. The House of Delegates would urge the development of a mechanism for meeting the needs for expansion of preventive medical services, extension of medical care for the indigent and the medically indigent, with local determination of needs and local control of administration, within the philosophy of the American form of government and without damage to the quality of medical service.
16. The fundamental question is how and when a state should be given financial aid by the federal government out of the resources of the states as a whole, pooled in the federal treasury.
17. The bizzare thinking which evolved the system of federal subsidies—sometimes called “grants-in-aid”—is used to induce states to carry on activities suggested frequently in the first instance by officers and employees of the federal government.
18. The use of federal subsidies to accomplish such federally determined activities has invariably involved federal control.
19. Any state in actual need for the prevention of disease, the promotion of health and the care of the sick should be able to obtain such aid in a medical emergency without stimulating every other state to seek and to accept similar aid, and thus to have imposed on it the burden of federal control.
20. The mechanism by which this end is to be accomplished, whether through a federal agency to which any state in need of federal financial assistance can apply, or through a new agency created for this purpose or through responsible officers of existing federal agencies, must be developed by the Executive and the Congress, who are charged with these duties.
21. Such a method would afford to every state an agency to which it might apply for federal assistance without involving every other state in the Union or the entire government in the transaction.
22. Such a method would not disturb permanently the American concept of democratic government.

The Distinguished Service Award was presented to Dr. James B. Herrick of Chicago.

President Abell's address was a review of the past year with special reference to our relationship with the United States Government.

President-elect Sleyster confined his address to the internal workings of the organization. Both of the addresses should be read by all of the profession.

Changes were made in the By-laws covering the Reference Committee of Medical Education.

Many reports were read which are too many and too long to be incorporated in this report but which are printed in full in the *Journal of the American Medical Association*. It is not considered that they are of enough interest to the individual physician to repeat in this report.

The following officers were elected:

President-Elect—Nathan B. Van Etten of New York  
Vice President—Alphonse McMahon of St. Louis.  
Secretary—Olin West of Chicago.  
Treasurer—Herman L. Kretschmer of Chicago.  
Speaker—H. H. Shoulders of Nashville.  
Vice Speaker—R. W. Fouts of Omaha.  
Trustees—Roger I. Lee of Boston.  
E. L. Henderson of Louisville.

The 1942 convention was awarded to Atlantic City.

#### A. M. A. MEETING—ST. LOUIS

The total registration of the St. Louis session was 7,412. Of this number, 43 were from Florida. The representation of doctors from Florida outnumbered that of 23 other states. The report of Dr. Olin West, the secretary, indicates that the membership of the A. M. A. has increased to 113,113. The doctors from Florida who attended the St. Louis meeting were as follows:

*Arcadia*: H. P. Bevis. *Brewster*: Robert L. Tolle. *Coral Gables*: Jack Q. Cleveland, Warren W. Quillian. *Ft. Lauderdale*: Elliott M. Hendricks. *Jacksonville*: J. L. Borland, Gordon H. Ira, Frederick W. Krueger, Ferdinand Richards, W. McL. Shaw, H. Marshall Taylor. *Lake City*: J. F. Busey, Jr. *Lakeland*: John W. Vaughn. *Miami*: E. W. Cullipher, M. Jay Flipse, Robert M. Harris, Roy J. Holmes, George D. Lilly, E. Sterling Nichol, J. Randolph Perdue, M. C. Wilson. *Miami Beach*: Max Dobrin, David W. Exley, M. A. Kugel, Cayetano Panettiére, Frazier J. Payton. *Micanopy*: I. A. Dailey. *Orlando*: Dorothy D. Brame, Russell B. Carson, Eugene L. Jewett, Meredith Mallory. *Pensacola*: Herbert L. Bryans, James M. Hoffman, J. N. McLane, Carol C. Webb. *St. Petersburg*: James A. Bradley, N. M. Marr. *Sanford*: A. W. Knox. *Sarasota*: Joseph Halton. *Tampa*: J. C. Dickinson, Alvord L. Stone. *Winter Park*: Ben F. Hart, Ruth S. Hart.

#### THE FIFTH ANNUAL CLINICAL CONFERENCE OF THE FLORIDA SECTION OF THE SOUTHEASTERN SURGICAL CONGRESS

IN COOPERATION WITH THE  
MARION COUNTY MEDICAL SOCIETY  
AND THE  
MUNROE MEMORIAL HOSPITAL  
OCALA

Thursday, August 24, 1939, at 10 a. m.

#### COMMITTEES

*For Southeastern Surgical Congress*

Frederick J. Waas, *Chairman*  
Edward Jelks                      Henry C. Dozier  
Joseph S. Stewart                Leland F. Carlton

*For Marion County Medical Society*

R. C. Cumming, *Chairman*  
James L. Chalker                R. D. Ferguson

#### SCIENTIFIC PROGRAM

Frederick J. Waas, *Presiding*

1. "Head Injuries," Edgar F. Fincher, Atlanta.
2. "Tumors of the Breast," W. A. Selman, Atlanta.
3. "Errors Which May Lead to Unnecessary Surgery," T. Z. Cason, Jacksonville.
4. "Diagnosis and Management of Surgical Lesions of the Colon," R. L. Sanders, Memphis, President, Southeastern Surgical Congress.

Lunch at Hotel Marion

(*Courtesy Munroe Memorial Hospital*)

12:30 p. m.

5. "Aims of the Southeastern Surgical Congress," B. T. Beasley, Atlanta, Sec'y., Southeastern Surgical Congress.
6. "Some Phases of Kidney Surgery," Grady N. Coker, Canton, Ga., Past President, Medical Assn. of Georgia.
7. "Complications in Gallbladder Surgery," J. S. Turberville, Century, President-elect, Florida Medical Assn.
8. "Surgical Treatment of Gastric and Duodenal Ulcers," J. K. Quattlebaum, Savannah.
9. "Cardiac Irregularities as Related to Surgery," G. O. Segrest, Mobile.

This program will consist of presentation of cases and case reports followed by discussions from the floor. There will be no set papers. All members of the Florida Medical Association are cordially invited to be present. Clinical sessions and lunch will be held in the Hotel Marion.

#### STATE NEWS ITEMS

Dr. and Mrs. H. A. Barge of Miami have returned from a vacation trip. They spent some time in Atlanta and Newnan, Georgia; then went to Baltimore where Doctor Barge joined the degree team of the Mobi Temple at the National Shrine Convention. They also visited the World's Fair.

Dr. W. H. McCullagh of Jacksonville was certified by the American Board of Neurology and Psychiatry, after satisfactorily passing the examination held in Chicago, June 14.

\* \* \*

Dr. and Mrs. E. W. Cullipher of Miami recently returned from a month's motor trip through the midwest. Enroute, they stopped at St. Louis where Doctor Cullipher attended the meeting of the A. M. A.

\* \* \*

Dr. J. Maxey Dell, Jr., and family, of Gainesville spent the month of June in Washington, D. C., where Doctor Dell took special work at the Warwick Memorial Cancer Clinic and the Children's Hospital.

\* \* \*

Dr. William M. McKibben of Miami has returned from a family reunion and wedding at Van Buren, Arkansas. He went by way of New Orleans, Texas and Oklahoma, returning via Memphis and Birmingham.

\* \* \*

Dr. Don C. Robertson and family of Orlando have returned from a two weeks' visit in Miami Beach where they were the guests of Dr. and Mrs. Carl S. McLemore.

\* \* \*

Dr. R. M. Fleming of Miami visited tumor clinics of the metropolitan New York area in June. He was present at the opening ceremonies of the new Memorial Hospital in New York City, the world's largest cancer hospital, on June 14.

\* \* \*

Dr. Shaler Richardson of Jacksonville and Dr. Nelson M. Black of Miami attended the annual meeting of the American Ophthalmological Society held at Hot Springs, Virginia, in June.

\* \* \*

Dr. Joseph Halton of Sarasota is doing postgraduate work at the Mayo Clinic in Rochester, Minn., during the month of July.

\* \* \*

Dr. George R. Creekmore of Brooksville was recently appointed as a member of the Board of County Commissioners by Governor Fred P. Cone, to fill a vacancy caused by the resignation of W. M. Russell. The office to which Dr. Creekmore has been commissioned is the first to be held by him, although he has been a citizen of Brooksville for more than 22 years.

Dr. Claude Anderson of Orlando recently returned from Boston where he attended a clinical meeting of the former Fellows of the Lahey Clinic.

\* \* \*

Dr. J. I. Thorne of Miami has returned from a month's trip abroad. During this time he spent seven days in Amsterdam where he received personal instruction from Dr. Jules Samuels on the study of endocrine therapy via short wave stimulation and spectroscopic study of oxyhemoglobin activity.

\* \* \*

The Orange County Medical Society is staging its annual barbecue and picnic in Orlando, Thursday, August 31. All members of the Florida Medical Association are cordially invited. You will have no trouble finding the picnic grounds. Just inquire when you arrive at Orlando.

\* \* \*

Dr. James A. Bradley of St. Petersburg was certified by the American Board of Internal Medicine as a specialist, according to a letter dated June 5, 1939, from the Board's Madison, Wisconsin, office.

## LOUIS SIMS OPPENHEIMER

Dr. Louis S. Oppenheimer, one of Tampa's oldest and best-known physicians and a prominent civic, fraternal and charitable worker, died June 12 of a heart attack, at Perry while enroute to Montgomery, Alabama, to visit his daughter, Mrs. Alfred Haas.

Born Jan. 24, 1854, at Louisville, Ky., Doctor Oppenheimer received the foundation of his education at Louisville University, studying later in schools in Europe and hospitals in New York. He practiced a few years at Louisville and Seymour, Ind., and operated a drug store at Savannah.

In 1886 Doctor Oppenheimer moved to Bartow and opened a drug store. He married Miss Alberta Dozier, daughter of a Methodist minister, on June 20, 1888. When the "big freeze" destroyed the Florida citrus crop in 1896, he moved to Tampa and started practice.

He became house physician of the famous Tampa Bay Hotel, and served during its business peak when many of the nation's lead-



ers were guests there. The pioneer delivered hundreds of Tampa babies and attended thousands of Tampans during his career. Surgery was crude in the early days, and Doctor Oppenheimer performed many operations in patients' kitchens with instruments sterilized on a cook stove.

A past president and past secretary of the Hillsborough County Medical Society, Doctor Oppenheimer became the first life member of the organization in 1932. He was past vice president and an honorary member of the Florida Medical Association, past president of the Florida Railway Surgeons' Association and past president of the Seaboard Air Line Surgeons' Association.

He served as general surgeon for the Florida Fair Association for many years and was reelected at the annual meeting a week before his death.

Other medical honors and achievements included associate editor of the *International Journal of Surgery*; associate editor of the *American Medicine*; member of the Medical Editors' Association; ex-officio assistant professor at the University of Vienna; member of the faculty of the University of Louisville; surgeon for the Seaboard Air Line and Tampa Electric Co.; past president of the Jackson County Medical Society of Seymour, Ind.; member of the American Medical Association, the Kentucky Medical Society, and the Tri-State Medical Society of Kentucky, Indiana and Illinois; consulting surgeon for the Louisville, Ky., City Hospital; and surgeon for the Pennsylvania Railroad.

In civic affairs, also, Doctor Oppenheimer was prominent. He was the father of the Tampa Chapter of the American Red Cross, and was honorary chairman of the chapter. He was assistant chief surgeon of the Sons of Confederate Veterans and a major in the Florida National Guard.

Fraternal organizations also received attention from Doctor Oppenheimer, who has been called Tampa's "grand old man of masonry." He was a past master of John Darling Lodge, F. & A. M.; past grand master of Prospect Lodge of Odd Fellows; past chancellor of Bay Lodge, Knights of Pythias; past consul commander of Hillsborough Lodge, Woodmen of the World; past preceptor, Tampa Consistory of Scottish Rite; past grand tall cedar, Tampa Lodge, Tall Cedars

of Lebanon; and honorary member of Fellowship and Windhorst Masonic Lodges and Pythagoras Lodge, K. of P.

Doctor Oppenheimer is survived by his widow, Mrs. Alberta Dozier Oppenheimer; a son, Louis Oppenheimer, Tampa; five daughters, Mrs. Hortense Leopold, Mrs. Oliva Schofield and Mrs. Carmen Hirsch, Tampa; Mrs. Irma Haas, Montgomery, Ala.; and Mrs. Dorothy Breckenridge, Houston, Tex.; a brother, Dr. William S. Oppenheimer, and eight grandchildren.

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### LEWIS PIERCE

Dr. Lewis Pierce, aged 39, one of Marianna's leading physicians, born in Marianna, Florida, in 1900, died as a result of an automobile accident in Thomaston, Georgia, Saturday, May 27, 1939.

Doctor Pierce received his medical education at Emory University at Atlanta, Georgia, graduating in 1926. He served his internship at St. Joseph's Hospital, Atlanta, and was appointed as one of the seven house physicians at Wesley Memorial Hospital, Atlanta, practicing in this capacity for about a year. He began his practice in Atlanta, Georgia, an associate with Dr. Clarence Johnson, later going to Jacksonville, Florida, where he was associated with Dr. Ralph Greene.

During the fall of 1929 he moved to Marianna, where he continued his practice until the time of his death. In 1928 Dr. Pierce married Miss Eddie Smith of Atlanta, to whom three children were born. A member of the Methodist Church, he was one of Marianna's foremost citizens with an enviable record as a well-trained and competent physician. He was a member of the Phi Beta Pi medical fraternity, Sigma Alpha Epsilon fraternity, a lieutenant in the U. S. Army Reserve Medical Corps, member of the Jackson County Medical Society, member of the Florida Medical Association, the Chattahoochee Valley Medical Society, the Southern Medical Association, and the American Medical Association.

He is survived by his widow and three small sons, James Lewis, Jr., 8, Edward Smith, 5, and Robert S., III, 3; his mother and father, Dr. R. S. and Mrs. Ella Lewis Pierce; one sister, Miss Elizabeth Pierce;

one brother, R. S., Jr.; and a great many friends and relatives who will learn of his death with sincere regret.

The following resolution was passed by the Jackson County Medical Society at the regular meeting held June 8, 1939:

*Whereas*, God in His infinite wisdom hath seen fit to remove from our midst one of our most beloved brothers, Dr. Lewis Pierce, and

*Whereas*, by his untiring and studious devotion to the practice of medicine and continued sacrifices in the interests of his profession, he endeared himself to the entire community, and

*Whereas*, we, the members of the Jackson County Medical Society, feel deeply the loss of our esteemed brother and friend; therefore, be it

RESOLVED, That the Jackson County Medical Society express its sorrow in the passing of Dr. Lewis Pierce; that a copy of this resolution be sent to his wife; that a copy be entered on the minutes of this society; and that the same be published in the Journal of the Florida Medical Association.

## BIRTHS, MARRIAGES AND DEATHS

### BIRTHS

Dr. and Mrs. R. Sam Moseley of Miami announce the birth of a son, Robert Samuel, Jr., on Thursday, June 22, at the Jackson Memorial Hospital.

\* \* \*

Dr. and Mrs. C. D. Hoffmann of Orlando announce the birth of a son, Latta Autrey, March 30, at the Orange General Hospital.

\* \* \*

Dr. and Mrs. Robert M. Baker of Jacksonville announce the birth of a son, George Robert Henderson, June 5, in St. Vincent's Hospital.

### MARRIAGES

Dr. G. C. Ferrante and Miss Rose Marie Ferlita, both of Tampa, were married on June 4, 1939.

### DEATHS

Dr. Louis S. Oppenheimer of Tampa died June 12 at Perry of a heart attack, while enroute to Montgomery, Alabama, to visit a daughter.

## MEDICAL DISTRICT MEETINGS 1939



Marianna (A) . . . . July 20

Palatka (C) . . . . Sept. 14

Lakeland (D) . . . . Sept. 28

West Palm Beach (F) Oct. 12

Ocala (B) . . . . . Oct. 26

Sanford (E) . . . . . Nov. 9

*Any member who wishes to read a scientific paper at his district meeting is urged to make application immediately. From applications received four essayists will be selected by the senior councilor in each district. Mail your application to Box 1018, Jacksonville, Florida.*

## COMPONENT COUNTY SOCIETIES

### BROWARD COUNTY MEDICAL SOCIETY

At the May meeting of the Broward County Medical Society, Dr. Leigh F. Robinson, president of the Florida Medical Association, was presented with a Hamilton watch, as a token of the society's appreciation of his work and to honor him upon his elevation to the presidency. The presentation was made by Dr. R. L. Elliston, president of the Broward County Medical Society, and was gratefully acknowledged by Doctor Robinson.

\* \* \*

### DADE COUNTY MEDICAL SOCIETY

A postponed meeting of the Dade County Medical Society was held on the evening of July 12 in the Ingraham Building. The scientific program consisted of a symposium on Medical Economics, presented as follows:

(a) Present Status of Hospital Insurance—George D. Lilly.

(b) Present Status of Medical Insurance—Walter T. Hotchkiss.

(c) Cost of Special Procedures, X-ray, Laboratory, etc.

\* \* \*

### DUVAL COUNTY MEDICAL SOCIETY

The June meeting of the Duval County Medical Society was held in the Assembly Room of the Old Inn of the Ponte Vedra Country Club, on the evening of June 21. Dr. R. W. McNealy, Associate Professor of Surgery at Northwestern University, Chicago, was principal speaker, using as his subject "Recent Advances in Preoperative Care of Patients."

Invitations to this meeting were extended to all doctors in attendance at the Medical Short Course at Daytona Beach.

Following the scientific program, a buffet supper and dance were enjoyed at the Ponte Vedra Bath Club.

\* \* \*

### JACKSON COUNTY MEDICAL SOCIETY

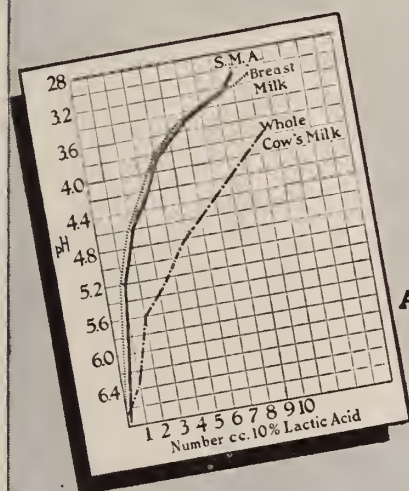
Dr. C. C. Box of Graceville, vice president of the Jackson County Medical Society, presided at the meeting held June 7, in the absence of Dr. C. J. Price of Alford, president. Plans were discussed for the coming meeting of the Northwest Medical District (A), to be held in Marianna, July 20.

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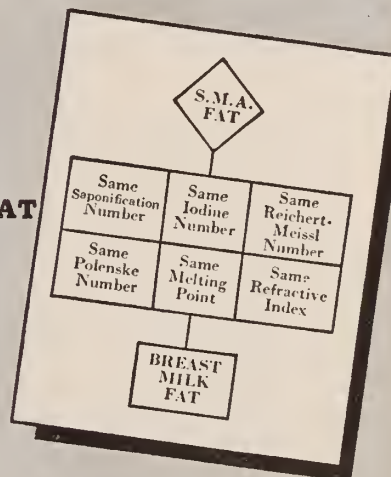
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PASCO-HERNANDO-CITRUS COUNTY MEDICAL  
SOCIETY

Drs. William B. Moon and P. J. Hudson entertained the members of the Pasco-Hernando-Citrus County Medical Society at a sight-seeing and fishing trip on Thursday evening, June 8.

"Hazel," the beautiful boat of C. W. Croft of Homosassa was chartered for the occasion. The trip included a run down the river, a distance of 6 miles, and 3 miles in the gulf. A fish dinner was served on the boat. At a scientific session held en route, Dr. Claude L. Carter and other members gave interesting case reports.

A vote of thanks was extended to Doctors Moon and Hudson for this delightful trip. Appreciation was also expressed to Mr. Croft whose completely furnished boat and wonderful fish dinner were so thoroughly enjoyed. Those who attended were: Dr. Claude L. Carter of Inverness; Dr. and Mrs. G. R. Creekmore and Dr. and Mrs. S. C. Harvard of Brooksville; Dr. and Mrs. W. B. Moon and Dr. and Mrs. P. J. Hudson and daughter of Crystal River.

\* \* \*

## PINELLAS COUNTY MEDICAL SOCIETY

Dr. Paul L. White of St. Petersburg was principal speaker at the meeting of the Pinellas County Medical Society held on the evening of June 2 at the Chatterbox. Doctor White presented a paper on "Pernicious Anemia."

The initial Academy Program of the Society was held in Sunshine Hall, Power and Light Building at 8 o'clock on June 16, the following subjects being presented:

"Arteriosclerotic Heart Disease," N. M. Marr.

"Cholecystitis," R. W. S. Owen.

"Intra-ocular Tension," R. D. Murphy.

\* \* \*

## POLK COUNTY MEDICAL SOCIETY

Dr. J. W. Annis of Lakeland was the featured speaker at the meeting of the Polk County Medical Society held at the Lake Region Dining Room, Wednesday evening, June 14. His subject was "Cardiac Arrhythmias."

The Woman's Auxiliary held a meeting at the same time in the coffee shop.

## ABSTRACT DEPARTMENT

*Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.*

**The Hygiene of Swimming, TAYLOR, H. MARSHALL, Jacksonville, *Virginia M. Monthly*, 66: 32-35 (January), 1939.**

The relationship of infections of the sinuses and ears from swimming is not so much due to infected water or high concentrations of chemicals used in sterilizing swimming pool waters, as to the fact that man as a terrestrial being is poorly equipped and ill adapted to aquatic life or even temporary exposures to an aquatic environment.

Structurally, man is poorly adapted to an aquatic environment, because unlike saurians, certain birds, and mammals such as the hippopotamus, he has no folds or muscles capable of closing off the nares and ears on submersion in water, and on such immersion, especially if it is forcible, the nasal mucus which is protective is washed away leaving the nasal membranes free to the destructive action of water. Moreover, in assuming the upright position, man lost the ability to drain his sinuses by gravity, and had to depend on a normal ciliated mucosa for drainage of his sinuses, which mucosa he cannot protect from immersion. So man is peculiarly liable to injury to his nasal membranes in swimming.

Infection of the nose and sinuses in man following swimming may depend not only on his poor structural adaptation to the aquatic environment, but also on the fact that he lowers his resistance to infection by immersion. By prolonged immersion man not only washes away his protective nasal mucus to allow easier entrance of bacteria, but he also rapidly cools his body as water at 70° F. cools the body twenty-seven times faster than air. Such cooling may produce anoxemia, depression of the automatic nervous system with vasoconstriction and lowered local resistance, decreased phagocytic ability, and increased metabolism which will rapidly reduce energy for resistance to infection.

Taylor recommends that swimming be limited to half-hour periods and that all swimmers learn proper breathing methods of exhaling while submerged and inhaling while



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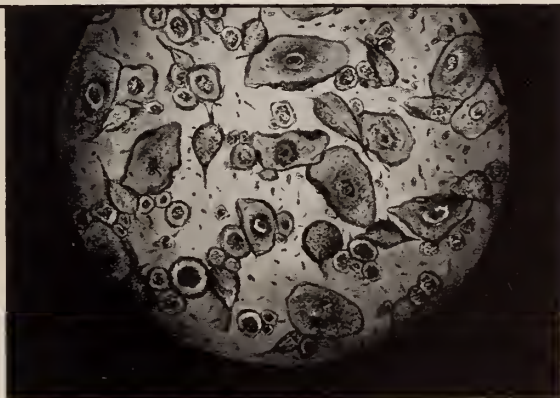
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above water, and especially to take in air before diving; diving feet first is especially indicated as causing forceful pressure of water into the nose and sinuses.

**Diagnosis of Diabetes in Patients Taking Thiamin Chloride, HART, RUTH S., and WISE, LOUIS E., Winter Park, J. A. M. A. 112: 423 (Feb. 4), 1939.**

The authors discuss the possibility of patients on thiamin chloride producing sugar-reducing agents in the urine and describe a case in which sugar was found in the urine of such a patient despite a blood sugar of 90 mg.

The possibilities were:

1. Marked interval elimination of stored thiamin.
2. Elimination of oxidizable degradation products of the same.
3. Elimination of oxidizable degradation products of theophylline with ethylenediamine or phenobarbital or both, which the patient was also taking.
4. Lowering of the renal threshold to dextrose through the agency of thiamin chloride.

**Skeletal Traction in Fractures of the Radius and the Ulna, JEWETT, EUGENE L., Orlando, J. Bone & Joint Surg. 20: 206-8 (Jan.), 1938.**

Jewett describes an ingenious method of reducing and placing in fixation a fracture of both bones of the forearm, a little above the wrist joint, which had defied three attempts at closed reduction.

The arm was placed in a fracture frame, Kirschner wires were inserted through the olecranon and both lower fragments, and screws were fastened to the lower portion of both upper fragments. Separation of the wires produced sufficient extension to approximate the fragments and outward traction on the screws brought them into correct alignment, after which a non-padded plaster cast was applied. Pieces of tongue depressor were then placed between the hardened cast and the washers and heads of the screws and the ends of the screws were covered with plaster. Roentgenograms taken at two-week intervals showed maintenance of good position of the fragments.



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### AMERICAN OPTICAL CO.

American Optical Co. announces it is now in a position to supply the Otto Barkan Focal Illuminator. This Illuminator may be used as a small operating lamp, a hand slit-lamp, or as a transilluminator.

Its features are as follows: only  $4\frac{1}{2}$  inches over all, and weighs but five ounces; it may be held in the hand or attached by means of an adjustable bracket directly to the Micro-Gonioscope, Corneal Microscope, or Floor Stand. It operates on eight volts, the transformer being an integral part of the wall plug. The lamp remains remarkably cool even after long burning. The light source is an ordinary automobile bulb obtainable anywhere for a few cents.

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"Safeguarding Medicinal Products by Research and Control" is the subject of a vitally interesting exhibit at the New York World's Fair sponsored by E. R. Squibb & Sons. This exhibit, together with those of the American Medical Association, the Rockefeller Foundation, the American Public Health Association and similar organizations, as well as those of some other pharmaceutical houses, is located in the Medicine and Public Health Building on Constitution Mall near the Theme Center.

The average layman, who takes a prescription to his local drug store, is totally unaware of the great care taken by many agencies to assure that the drugs used in that preparation are pure and potent—capable of producing the result which his physician intended. In the Squibb exhibit, the World's Fair visitor learns of the safeguards established by the government, pharmacists, and reputable pharmaceutical manufacturers to the end that the patient may receive the greatest benefit from the physician's training and skill.

He sees examples of the U. S. Pharmacopoeia, the National Formulary and the various legal enactments whose ultimate purpose is the safeguarding of public

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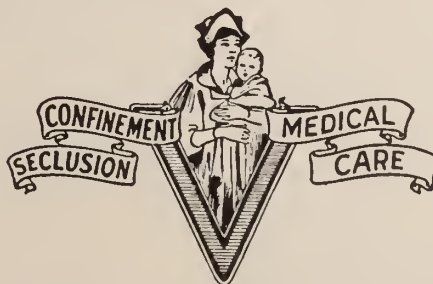
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health through the practical standardization of medicinal products. Beside these are specimens of the assay reference standards of many of the more important preparations used in medical practice. On adjoining panels is indicated something of that infinite variety of laboratory control tests which the conscientious manufacturer makes in order that the finished products will merit in all respects the full confidence of the physician.

Safeguarding drug products, however, is only half of the story. The Squibb exhibit also gives, by means of a few selected examples, an idea of what research is contributing toward the medicine of tomorrow.

Because of their immediate and popular interest, some of the results of recent investigations on vitamins are featured. Described in detail is one of the newer vitamins, vitamin K—the factor needed in certain conditions when the clotting power of the blood is delayed. Adjoining the vitamin K exhibit is a remarkable array of most of the known vitamins in crystalline form—a symbol of the achievement of the many investigators who have devoted their research mainly to the science of nutrition. Finally, tribute is given to the part played by the animal world in hastening and extending man's conquest of disease.

The entire exhibit encompasses much that is behind the scenes insofar as this tremendous activity is known to the layman. It will be a great revelation and should contribute to a feeling of added security for the visitor to see and learn something of the great effort being made by thousands of scientific workers in his interest and for the protection of his health.

## BOOKS RECEIVED

*Acknowledgment of books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review, as expedient.*

**DISEASES OF THE NOSE AND THROAT.** (Second Edition Revised.) By CHARLES J. IMPERATORI, M.D., F.A.C.S., Prof. of Otolaryngology, New York Polyclinic Medical School and Hospital, and HERMAN J. BURMAN, M.D., F.A.C.S., Adjunct Prof. of Otolaryngology, New York Polyclinic Medical School and Hospital. The purpose of this volume is stated in its preface: "The general practitioner and the senior medical student are constantly confronted with the problems: what is the diagnosis of this condition, and how shall I treat it? It is to answer these questions that the authors have written this book, which is essentially the course given to the matriculates at the New York Post-Graduate Medical School of Columbia University. A comprehensive description of the diseases most frequently encountered is given, while the less common conditions are briefly noted, and particular emphasis is placed on the necessity of thorough and routine examination." Cloth. Price \$7.00. Pp. 726, with 480 illustrations. Philadelphia: J. B. Lippincott Company, 1939.

**TRAUMA AND INTERNAL DISEASE: A BASIS FOR MEDICAL AND LEGAL EVALUATION OF THE ETIOLOGY, PATHOLOGY, CLINICAL PROCESSES FOLLOWING INJURY.** By FRANK W. SPICER, A.B., M.D., F.A.C.P. The material contained in this work, presented in 25 chapters, deals with trauma in its relation to the Brain, the Spinal Cord, the Chest and Respiratory System, Tuberculosis, the Heart, the Blood Vessels, the Abdomen, Gastric and Duodenal Ulcers, the Liver and Biliary System, the Pancreas, the Spleen, Appendicitis, the Genitro-Urinary System, the Female Genital Tract, Air Embolism, Diabetes, Exophthalmic Goiter, Leukemia, Arthritis, Syphilis, Electrical Injuries, and Tumors. Cloth. Price, \$7.00. Pp. 593, with 43 illustrations. Philadelphia: J. B. Lippincott Company, 1939.



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## WOMAN'S AUXILIARY

The Woman's Auxiliary and the Florida Medical Association's Advisory Committee to the Auxiliary held a joint meeting at Daytona Beach, Monday, June 19, following a dinner party held at the Sea Side Inn. Dr. Leigh F. Robinson, the Medical Association's president, was our guest of honor. The following charges were adopted and copies mailed to each county auxiliary president:

The first three we may consider our main objectives. The remainder, however, are in many respects no less important.

- I. Hold regional auxiliary meetings at the same time and place of the state district medical meetings as near as possible.
- II. Hold bigger and better third annual Health Institute day.
- III. Consider starting as a state objective, a medical school scholarship fund for a doctor's widow's son, or some deserving member of a doctor's family, this to be voted on at the next state medical meeting, in Tampa, a small amount to be prorated from each member.
1. Continue to publicize as widely as possible the necessity for periodic examinations of domestic servants, as well as periodic health examinations for all.
2. Hold yourself in readiness to cooperate 100 per cent with the chairman of the legislative committee.
3. See that your organization becomes informed about socialized medicine, and distribute literature on this subject. Literature may be obtained at the

following address: National Committee to Uphold Constitutional Government, 205 E. 42nd Street, New York, N. Y.

4. Cooperate with the Tuberculosis Association, particularly the Christmas seal sale.
5. Cooperate with the Southern Jane Todd Crawford Memorial scholarship fund.
6. Secure A. M. A. broadcasts over your local station and urge the schools of your county to permit the pupils to listen and make use of them in their science classes.
7. Continue diligently to distribute the magazine *Hygeia*.
8. Cooperate with the Cancer Field Army.
9. Prepare an interesting exhibit for the state medical meeting.
10. Secure the health education program, 1939-40, of the National Auxiliary from Mrs. V. E. Holcombe, 1635 Quarrier Street, Charleston, West Virginia.

If I can be of any further service in helping you outline your program for the coming year, please feel free to call upon me.

MRS. GORDON H. IRA,  
*Program Chairman.*

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**FRACTURES & TRAUMATIC SURGERY**—Ten Day Formal Course September 25th. Informal Course every week.

**OTOLARYNGOLOGY**—Two Weeks' Intensive Course starting September 11. Informal Course every week.

**OPHTHALMOLOGY**—Two Weeks' Intensive Course starting September 25. Informal Course every week.

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## COMPONENT SOCIETIES BY DISTRICTS — FLORIDA MEDICAL ASSOCIATION

District	COUNTY SOCIETIES	PRESIDENT	SECRETARY	MEETING DATE	COUNCILOR and Counties Not Included in First Column	Members	
						Total	Paid
Northwest District (A) Mariana July 20, 1939	Bay	Donald S. Fraser, M.D. Panama City	William C. Roberts, M.D. Panama City		A-1-'40 Carol C. Webb, M.D. Pensacola	12	100%
	Escambia	L. C. Fisher, Jr., M.D. 816 N. Palafox St. Pensacola	J. M. Hoffman, M.D. 1221 E. DeSoto St. Pensacola	2nd Tuesday 8:00 P. M.		44	37
	Walton-Okaloosa	A. G. Williams, M.D. Lakewood	R. B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P. M.		6	100%
	Washington-Holmes	W. D. Ramsey, M.D. Nona	L. H. Paul, M.D. Bonifay		Santa Rosa	8	7
	Franklin-Gulf	Chapman Dykes, M.D. Carrabelle	A. L. Ward, M.D. Port St. Joe	3rd Thursday	A-2-'41 B. A. Wilkinson, M.D. Tallahassee	6	100%
	Jackson	C. J. Price, M.D. Alford	R. N. Joyner, M.D. Mariana	2nd Tuesday 7:30 P. M.		13	12
	Leon-Gadsden-Liberty-Wakulla-Jefferson	W. W. Massey, M.D. 204 N. Madison St. Quincy	B. A. Wilkinson, M.D. Telephone Bldg. Tallahassee	Quarterly 3:00 P. M.	Calhoun	40	31
North Central District (B) Ocala October 26, 1939	Columbia	W. M. Ives, M.D. 132 N. Marion St. Lake City	Harry S. Howell, M.D. Blanche Hotel Annex Lake City	1st Monday 7:30 P. M.	B-3-'41 W. S. Nichols, M.D. Lake City	21	16
	Madison	E. Long, M.D. Madison	A. F. Herrison, M.D. Madison			3	2
	Taylor	Geo. H. Werren, M.D. Perry	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P. M.	Baker-Dixie-Hamilton-Lafayette-Suwannee	8	6
	Alachua	J. E. Melnes, Jr., M.D. 433 E. Main St. N. Gainesville	J. Maxey Dell, Jr., M.D. 333 W. Main St., S. Gainesville	2nd Friday 7:30 P. M.	B-4-'40 James L. Strange, M.D. McIntosh	28	21
	Marion	Carl S. Lytle, M.D. Dunnellon	R. C. Cumming, M.D. Commercial Bank Bldg. Ocala	3rd Thursday 12:30 P. M.		23	100%
	Pasco-Hernando-Citrus	Claude L. Carter, M.D. Inverness	G. R. Creechmore, M.D. Brooksville	2nd Thursday 7:00 P. M.		15	100%
	Sumter	Clyde L. Carter, M.D. Wildwood		2nd Tuesday	Bradford-Gilchrist-Levy-Union	3	2
N. E. District (C) Palatka September 14, 1939	Duval	Thomas E. Buckner, M.D. 1022 Park St. Jacksonville	Lauren M. Sompeyrac, M.D. 459 St. James Bldg. Jacksonville	1st Tuesday 8:15 P. M.	C-5-'41 R. B. McIver, M.D. Jacksonville	173	169
	St. Johns	R. D. Harris, M.D. St. Augustine	G. Walter Potter, M.D. East Coast Hospital St. Augustine	3rd Tuesday 8:30 P. M.	Clay-Nassau	10	100%
	Putnam	Edward W. Ford, M.D. Crescent City	C. M. Knight, M.D. Palatka	2nd Tuesday in Feb., April, June, Aug., Oct., Dec. 7:00 P. M.	C-6-'40 George M. Green, M.D. Daytona Beach	11	10
	Volusia	Maximilian Stern, M.D. Box 5038 Daytona Beach	R. L. Miller, M.D. 258 1/2 S. Beach St. Daytona Beach	2nd Tuesday 7:30 P. M.	Flagler	41	37
	Hillsborough	J. W. Alsobrook, M.D. 120 N. Collins St. Plant City	James S. Grable, M. D. 811 Citizens Bank Bldg. Tampa	1st Tuesday 8:00 P. M.	D-7-'41 W. C. McConnell, M.D. St. Petersburg	110	94
Southwest District (D) Lakeland September 28, 1939	Manatee	S. G. Hollingsworth, M.D. 451 12th St. Bradenton	M. M. Harrison, M.D. Professional Bldg. Bradenton	3rd Tuesday 7:00 P. M.		13	100%
	Pinellas	E. C. MacCordy, M.D. 366 First Federal Bldg. St. Petersburg	W. C. McConnell, M.D. 1001 First Federal Bldg. St. Petersburg	1st and 3rd Fridays 6:30 P. M.		93	100%
	Sarasota	T. W. Taylor, M.D. Professional Bldg. Sarasota	Stanley T. Martin, M.D. Sarasota	2nd Tuesday 8:30 P. M.		17	10
	DeSoto-Hardee-Highlands-Charlotte-Glades	Ben D. Spears, M.D. Wauchula	Howard V. Weems, M.D. 22 Oak St. Sebring	2nd Tuesday 8:00 P. M.	D-8-40 Herman Watson, M.D. Lakeland	19	100%
	Lee	C. Gordon Merrick, M.D. 26 Leon Bldg. Fort Myers	H. L. Allen, M.D. 312 Pythian Bldg. Fort Myers	3rd Friday 7:30 P. M.		14	12
	Polk	John F. Wilson, Jr., M.D. Box 254 Lakeland	J. R. Boulware, Jr., M.D. P. O. Box 367 Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P. M.	Collier-Hendry	62	100%
	Brevard	W. J. Creel, M.D. Eau Gallie	I. K. Hicks, M.D. Melbourne	3rd Tuesday	E-9-'40 W. C. Page, M.D. Cocoa	11	7
South Central District (E) Sanford November 9, 1939	Lake	W. G. DeVane, M.D. Groveland	Oliver Emerson, M.D. Tavares	1st Thursday 12:30 P. M.		18	13
	Orange	C. D. Hoffmann, M.D. 120 E. Robinson St. Orlando	Fred Mathers, M.D. Box 53 Orlando	3rd Wednesday 8:30 P. M.		77	72
	Seminole	Thomas F. McDaniel, M.D. Seminole County Bank Bldg. Sanford	Douglas G. Scott, M.D. 212 N. Perk Ave. Sanford	2nd Monday 7:00 P. M.	Osceola	12	100%
	St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D. Box 942 Stuart	Adrien M. Sample, M.D. Ft. Pierce	3rd Thursday 8:00 P. M.	E-10-'41 A. M. Sample, M.D. Ft. Pierce	17	100%
	Broward	R. L. Ellison, M.D. 814 Sweet Bldg. Ft. Lauderdale	Oliver C. Brown, M.D. 915 Sweet Bldg. Fort Lauderdale	4th Wednesday 8:00 P. M.	F-11-'40 Lloyd J. Netto, M.D. West Palm Beach	33	100%
S. E. District (F) West Palm Beach October 12, 1939	Palm Beach	Gaylord Lewis, M.D. 916 Harvey Bldg. W. Palm Beach	C. Jennings Derrick, M.D. Box 574 W. Palm Beach	4th Monday 8:00 P. M.		58	100%
	Dade	M. Jay Flipse, M.D. 305 Huntington Bldg. Miami	Franz Stewart, M.D. 1105 Huntington Bldg. Miami	1st Tuesday 8:30 P. M.	F-12-'41 Kenneth Phillips, M.D. Miami	296	262
	Monroe	Harry C. Geley, M.D. 532 Fleming St. Key West	W. R. Werren, M.D. 511 Eaton St. Key West	1st Sunday 9:00 P. M.		4	100%

STATE AND SECTIONAL MEETINGS

SOCIETY	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association.....	Leigh F. Robinson, Ft. Lauderdale	Shaler Richardson, Jacksonville....	Tampa, 1940
Florida Medical Districts:			
1—Northwest .....	Carol C. Webb, Pensacola.....	Stewart Thompson, Jacksonville....	Marianna, July 20, 1939
2—North Central .....	J. L. Strange, McIntosh.....	" " "	Ocala, Oct. 26, 1939
3—Northeast .....	George M. Green, Daytona Beach.....	" " "	Palatka, Sept. 14, 1939
4—Southwest .....	Herman Watson, Lakeland.....	" " "	Lakeland, Sept. 28, 1939
5—South Central .....	W. C. Page, Cocoa.....	" " "	Sanford, Nov. 9, 1939
6—Southeast .....	Lloyd J. Netto, West Palm Beach.....	" " "	West Palm Beach, Oct. 12, 1939
Alabama Medical Association.....	M. S. Davie, Dothan.....	D. L. Cannon, Montgomery.....	Birmingham, April 16-18, 1940
Georgia Medical Assn. of.....	W. H. Myers, Savannah.....	E. D. Shanks, Atlanta.....	Savannah, April 23-26, 1940
Florida—			
State Dental Association.....	R. P. Taylor, Jacksonville.....	E. C. Lunsford, Miami.....	West Palm Beach, Oct. 12-14, 1939
Soc. of Derm. and Syph.....	Elmo D. French, Miami.....	Lauren M. Sompayrac, Jacksonville.....	Jacksonville, Nov. 1939
East Coast Medical Association.....	Frederick J. Waas, Jacksonville.....	A. J. Logie, Jacksonville.....	Jacksonville, Nov. 10-11, 1939
State Hospital Association.....	J. H. Therrell, Chattahoochee.....	Mr. Fred M. Walker, Jacksonville.....	Mississippi, March, 1940
Assn. of Industrial Surgeons.....	C. E. Tumlin, Miami.....	A. M. Bidwell, Tampa.....	Tampa, 1940
Internists' Society.....	Norval M. Marr, St. Petersburg.....	Kenneth Phillips, Miami.....	Tampa, 1940
Medical Postgraduate Course.....	Turner Z. Cason, Jacksonville.....	Chairman.....	Jacksonville, 1940
Soc. of Ophthal. & Otol.....	S. B. Forbes, Tampa.....	Temporary Chairman.....	Tampa, 1940
State Nurses Association.....	Mrs. Inez Nelson, Orlando.....	Mrs. Phyllis Leonard, St. Augustine.....	Lakeland, Nov. 6-8, 1939
Pediatric Society.....	Warren W. Quillian, Coral Gables.....	G. N. Leonard, Miami Beach.....	Tampa, 1940
Pharmaceutical Association.....	Mr. S. F. Harris, Jacksonville.....	Mr. A. W. Morrison, Miami.....	Tampa, May, 1940
Public Health Association.....	Mr. S. D. Macready, W. P. Beach.....	E. M. L'Engle, Jacksonville.....	Jacksonville, 1939
Radiological Society.....	H. B. McEuen, Jacksonville.....	J. N. Moore, Ocala.....	Tampa, 1940
Railway Surgeons' Association.....	H. D. Clark, Ft. Pierce.....	W. C. Page, Cocoa.....	Tampa, 1940
Tuberculosis & Health Assn.....	Mr. G. E. Therry, W. Palm Beach.....	Mrs. May Pynchon, Jacksonville.....	Spring, 1940
Chattahoochee Valley Med. Assn.....	J. S. Turberville, Century.....	Frank K. Boland, Atlanta.....	Albany, Ga., July 11-13, 1939
West Coast Clinical Society.....	J. H. Dodson, Mobile.....	C. C. Rouse, Mobile.....	Mobile, Oct. 26-27, 1939
Internat. Assn. Milk Sanitarians.....	Mr. V. M. Ehlers, Austin, Texas.....	Mr. C. Sidney Leete, Albany, N. Y.....	Jacksonville, Oct. 25-27, 1939
Midwestern Derm. Assn.....	J. R. Allison, Columbia.....	Howard King, Nashville.....	Nashville, Sept. 3, 1939
Midwestern Surgical Congress.....	R. L. Sanders, Memphis.....	B. T. Beasley, Atlanta.....	Birmingham, Mar. 11-13, 1940
Midwestern Medical Association.....	W. E. Vest, Huntington, W. Va.....	Mr. C. P. Lorz, Birmingham.....	Memphis, Nov. 21-24, 1939
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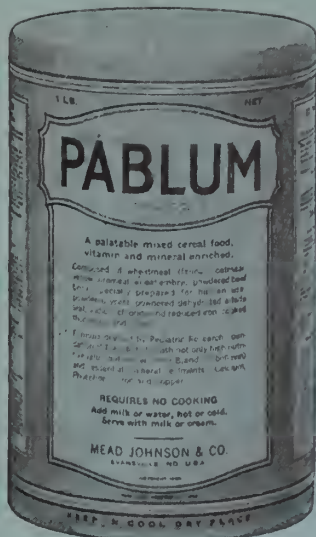
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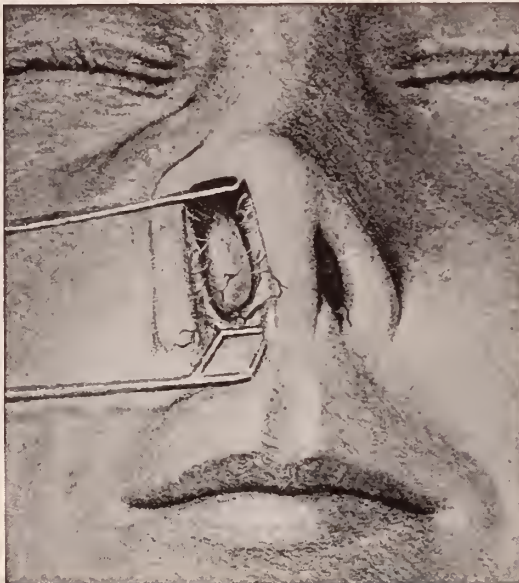


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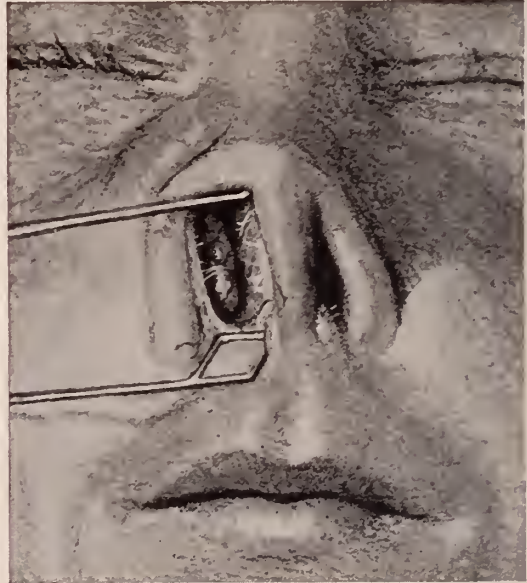
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Number 2

## PUERPERAL INFECTION VS. THE GENERAL PRACTITIONER

WILLIAM CARMEL ROBERTS, M.D.  
Panama City

Not unlike any other contest, be it a game of athletics, wits or politics, the contest between bacterial invasion and the general practitioner in the game of Childbirth has been and always will be one of paramount importance, not only to the medical profession, but also to the present and future generations.

Perhaps it would be better if the game could be played only by the trained specialists—big leaguers or professionals so to speak—but it so happens that the general practitioners or amateurs are the ones who play it most, and upon these men rests the responsibility of winning most of the games played. I do not wish to ridicule or discredit the amateurs, for oftentimes the amateur is as good as or better than the professional but just hasn't turned "pro." Other facts, fancies, and responsibilities have forced him to retain his amateur rank and standing.

Since the time of Semmelweis, Holmes, Pasteur and Doderlein with their great contributions we have been steadily improving our game and, I think, playing a winning game. However, until we progress to the point where we will win every game played, we must continue to learn more about guarding the defense and progressing with the offense.

The three most important periods in which to win the contest are the prophylactic, diagnostic and curative periods. We must use our most effective plays during these periods if we emerge from the contest victorious.

During the prophylactic period there are some practical measures which will aid in preventing bacteria from scoring. We know it is not practical, however ideal it would be, for the general practitioner to be as well equipped as a modern maternity hospital, but equipment plays a big part in preventing puerperal

infection. Too many general practitioners treat pneumonia, typhoid fever, abscesses, boils, carbuncles, tonsilitis, upper respiratory infections, influenza, erysipelas, abortions and, last but not least, obstetrics out of the same handbag. Every doctor who furnishes his own equipment should have a well equipped obstetrical bag separate and apart from other equipment. Sterile sheets, towels, gauze and rubber gloves seem troublesome and impractical, but these should be included in every accoucheur's equipment. Expensive autoclaves and sterilizers are not necessary. An efficient steam pressure sterilizer can be had at a very low cost. Every general practitioner should be equipped with this as well as with an adequate water sterilizer, even if it is only a simple water boiling apparatus used in the kitchen.

It is necessary to use sterile linens only during the second and third stages of labor; therefore, an adequate amount can easily be had for each delivery. The fact that they get contaminated and messed up soon after they are put into use is often the excuse for not using them routinely, but contaminated sterile linen is better than linen which has never been sterilized. A sterile delivery gown should be used by the doctor during the second and third stage procedures for the same reason that other sterile linens are used. Sterile rubber gloves should be used in all contact procedures about the birth canal, but a sterile glove does not excuse a dirty hand. Do not be afraid to use soap, water and a good scrub brush on your hands before putting on the sterile gloves. Somehow a doctor learns naturally in medical school that all surgical instruments must be sterile before using, but I want to emphasize that other materials used in the operative field also must be sterile. Let us consider, briefly, some of the "do's" and "don't's" that will aid in our defensive game.

In well supervised prenatal care thorough physical and laboratory examinations are necessary along with an accurate past history to be sure there are no contraindications for entering the contest, such as tuberculosis, malignant and benign growths, severe heart or



renal disease, or blood dyscrasiae. All foci of infection must be cleared up as far as practical and plausible. A heroic effort should be made to determine whether the patient has syphilis. With our present day public health facilities in Florida, any doctor who attends a parturient woman and does not make a real effort to determine if she is a victim of syphilis is, in my opinion, guilty of malpractice and should be dealt with accordingly. Gentlemen, there is no excuse for this oversight. Early pelvimetry and pelvic examination will classify the oncoming contest as normal, doubtful, or positive with reference to the need of interference or special watchfulness. Explicit directions are necessary with reference to general health measures, such as fresh air, diet, exercise, bath and attention to bowels. Special attention should be given to weight gain and water balance. Too much and too rapid weight gain probably means toxemia, which is a predisposing factor in infection. It is essential to guard against the patient becoming too anemic, for an anemic person does not have the proper fighting power to ward off infections. The diet must contain sufficient vitamins, especially A and D, to develop and maintain in tissues a resistance to bacterial invasion. Frequent stated blood pressure readings and urinalyses are the best guides in detecting that toxemia is threatening, which will aid bacteria to score. No vaginal examination should be made during the last six weeks of pregnancy, during labor or early puerperium unless abdominal and rectal examinations leave a doubt, when a vaginal examination may be made under strict aseptic or antiseptic precautions.

Rectal examinations to determine presentation, position and progress of the baby should be especially stressed, and are to be preferred to vaginal examination, but too little attention is given to the care of the rectum. Rectal examination as an obstetrical procedure is by no means foolproof. Infected hemorrhoids should be cleared up if possible. A good cleansing enema should be given every patient at the onset of labor if time will permit. The anus should be thoroughly cleansed with soap and water and a good antiseptic applied thereto. About one ounce of solution of merthiolate, 1:1000, instilled into the rectum after the enema will help destroy bacteria that habitate

the rectum. A sterile rubber glove need not be used in rectal examinations, but the introitus should be well protected with a sterile towel or gauze while the examination is being done. Examinations should be as few in number as possible, especially vaginal, throughout the entire contest. Interference with the process of labor is to be condemned; to be justified, definite indications on the part of the mother or baby must demand it. It must be remembered that the average time of labor is eighteen hours for the first and twelve to fourteen hours for subsequent deliveries; also that the time limit of the second stage of labor is two hours though conditions may prompt its curtailment or extension. Do not be too anxious to deliver the placenta; remember the one hour time of placental separation. Do not force it to separate prematurely by rough Crede maneuver. Here is the best opportunity to conserve the blood loss to the mother. The less the blood loss, the better chance to ward off infections. All repair work should be done as though it were a serious major operation. Too many lacerations go unrepaired and are, therefore, a breeding ground for bacteria. If a laceration is big enough to see, it is big enough to repair. Do not allow the patient to be catheterized unless absolutely necessary. It is a serious operation calling for the best aseptic technique; however it is necessary to catheterize before using forceps or doing version. Some recognized urinary antiseptic should be given for a few days after catheterization.

I want to refresh your memory of the most powerful and effective play used in this prophylactic period: the douch and swab, douch and swab, and douch mechanism in Nature's prophylaxis of labor. The membranes rupture and the douch of amniotic fluid washes out the birth canal; the birth of the baby is the swab that swabs out the canal; following the baby, more fluid along with some blood from placental separation douches the canal again; the placenta separates and passes through the canal and swabs it out again; this is followed by the final douch of blood. After this mechanism has been accomplished and no bacteria introduced into the canal from outside, then we have the game well in hand; defeat is not likely.

In the immediate postpartum period the accoucheur and his assistants must guard against contaminating the birth canal. A recognized antiseptic solution may be poured over the external genitalia before and after voiding or defecation. This will help to wash away surface bacteria that are potential infecting agents. If autoclaved sterile gauze pads cannot be had for the vulva pad, commercial products handled carefully may be permitted, such as Kotex, Modess, etc., for they are better than just clean cloth pads that are home made. Under no circumstances should the recent fancy tampon affairs used for feminine hygiene be used during the postpartum period for the chance to introduce bacteria into the birth canal is too great. An ergot preparation should be given along with quinine as both are credited with bacteriostatic action in addition to their uterine stimulating effect. The oxytocics should be given regularly for several days as they tend to accomplish better involution of the uterus, thereby expelling blood clots and retained secundae which favor bacterial growth and havoc. It is wise to place the patient in Fowler's position as this will aid in uterine drainage as well as involution. An ice cap placed on the lower abdomen is also beneficial in retarding bacterial growth.

For the extremely hot months, when the sweat will drip from the nose and chin upon the least exertion, or for the season when upper respiratory diseases are prevalent there is a simple, yet seldom done, procedure which may be life-saving. This is the use of a protecting mask over the nose, mouth and chin. The doctor should set the example and insist that all other people who attend the puerperal woman do likewise. It has been proved that a great percentage of the puerperal infections can be traced to upper respiratory infections of attendants as the source, especially in tonsillitis. If we cannot get the doctors to exercise the easy, simple, yet worthwhile procedures, then how are we to get them to exercise the more difficult ones? Doctors of medicine, let us not enter the contest of parturition the underdog. While we want to go into the game with the utmost confidence, we must not be over-confident, hopefully procrastinate and become negligent, lest such opposing players as streptococcus, staphylococcus, gonococcus, colon, typhoid, welchii, tetanus and Klebs-

Löffler bacilli score against us. In almost every contest the doctor has lost, one of these players did most of the scoring.

Why is puerperal infection most common following criminal abortion? It is because they are carelessly as well as criminally performed. Biologically speaking to deliver a baby from a sterile mother is a physiological impossibility, but bacteriologically speaking, to deliver a baby from a sterile mother is a real scientific achievement.

The second or diagnostic period of the game carries with it a good deal of responsibility and thought. In this period the "huddle system" or consultation should be welcomed. To make a diagnosis of early puerperal infection and beginning sepsis is by no means an easy one. If bacteria's march is to be halted their plays must be diagnosed early and broken up. After 72 hours, a sudden rise of temperature with or without a chill, should put the physician on guard. The fever may subside, but if it continues for 48 hours it is cause for alarm. A chill immediately after delivery is not alarming, but a repetition of chills followed by fever is a danger signal. This indicates that germs are all over the system. A fast, fine and thready pulse is a very good indicator of the severity of the infection. There is also a loss of appetite, malaise, dry mouth and a very ill patient. The lochia may or may not be foul smelling. The discharge depends on the amount of infection and putrefaction going on in the uterus.

There are many forms of puerperal infection. The lesions vary from minor ones to hopeless conditions, but the most common and the one that most concerns the general practitioner is that of endometritis. The best method of making a diagnosis of this condition early is by the process of elimination. The patient should be examined from head to foot, but the vaginal examination delayed for six or seven days if possible. This is indeed a risky procedure. However, every woman deserves a carefully performed vaginal examination ten days after labor. The fever may be caused by many things and a differential diagnosis must be made in such conditions as breast complications, pyelitis, specific fevers as typhoid, malaria and influenza, constipation toxemia, tonsillitis and tuberculosis. In making a diagnosis of endometritis there is a com-



mon condition often encountered, known as sapremia or putrid endometritis. A predisposing factor here is a poorly drained uterus. The causative factor is germs of saprogenic nature and of low virulence, attacking only sloughing tissue, and usually limited to retained secundae. After labor and during infectious processes, Nature lays down a protective wall of white blood cells under the endometrium and saprogenic organisms do not penetrate this wall, thereby causing no serious damage. The symptoms of this condition are usually fever, foul lochia, fast pulse but no chills, and are due to toxins from the putrid tissue and not from the organisms.

Sapremia is really a benign condition, but is a term we want to get away from, because a true sapremia is very, very rare. The diagnosis is usually that of a true endometritis. The endometritis caused from streptococcus and staphylococcus or any of the more virulent organisms is the condition that taxes the efforts of both the patient and physician. The bacteria attack the living tissue and develop a septic process quickly; they invade the endometrium, penetrate deeper, break through the protective wall of white blood cells, and even penetrate through the thrombotic uterine sinuses. Here they may stop and run their course as is often the case, but they may go still deeper into the lymphatics and blood stream and set up a local or general septicemia or peritonitis. General peritonitis from puerperal infection is usually 100 per cent fatal. Puerperal septicemia does not carry such a mortality rate as peritonitis, but the morbidity is far-reaching. The infection thromboses the pelvic veins, causing such long drawn out cases as phlegmasia alba dolens or milk leg, which is a common result of puerperal infection. There may be ulcerations of the vagina and perineum and at times a pseudo-membrane forms over them. Repaired and unrepaired lacerations of the vagina and perineum are infected. The uterus, as a rule, is tender and sub-involuted with tenderness about the adnexa, especially the tubes, and there may be frank suppuration in the pelvis. Much may be learned early from a carefully performed rectal examination, or, preferably from a vaginal examination, if after seven or ten days. The white blood count in puerperal sepsis is usually between 18,000 and 30,000. If the pa-

tient has fever of 102 F. or more for several days, a blood culture is in order and should be done if possible. Uterine cultures are advantageous if practical. Peritonitis from puerperal infection presents the same picture as that from any other source. The point to emphasize is the importance of an early diagnosis. At the earliest suspicion of beginning infection get busy and exhaust every means of clinching a diagnosis.

It is in the curative period of the game that it is necessary to cut loose with the most powerful and effective offensive plays, for bacteria has the upper hand. The treatment of puerperal infection is classified as "conservative medical" and "radical surgical." Conservative medical is the best, and is the treatment used by the general practitioner. In general, certain measures are always in order, such as: isolation and hospitalization if necessary; proper nourishment with plenty of fluids given any way to make them stick; and alkalization. The patient should be placed in Fowler's position to aid uterine drainage, involution, and to keep the infection in the pelvis; ice caps to lower abdomen at first, replaced, perhaps later if necessary, with heat treatment as in peritonitis. Ulcers, infected lacerations and sutures should be cleaned and accepted antiseptics applied. Blood transfusion may be necessary if the patient is anemic or has had prolonged sepsis. Small amounts, 250 cc. at a time, given often, seem to be better than larger ones. Douching a postpartum uterus should never be done.

The use of various serums has at times been encouraging, such as antistreptococcic, staphylococcic, tetanic, welchii, etc., but is, on the whole quite discouraging and disappointing. These serums should be given in large doses, even in the vein, if beneficial results are to be expected. In the hands of some, 25 cc. of 1 per cent mercurochrome per 100 lbs. of body weight given in the vein has been thought to be effective. Bacteriophage treatment has been advocated but never proved popular. Probably the latest and potentially the greatest contribution to the general practitioner in his efforts to treat puerperal infections is the organic dye preparations such as prontosil, prontolyn, sulfanilamide and sulfapyridine. These preparations have also been advocated as prophylactic measures. Every doctor should ac-



quaint himself with these preparations, their virtues and their application; keep at all times abreast with their developments, for it seems they are a revelation to him in his efforts to help the woman suffering with childbed fever.

When the contest is over and your summary is compiled, not only must you consider whether you won or lost, but how you played the game.

*119 Cove Boulevard.*

## DISCUSSION

*Dr. J. M. Hoffman, Pensacola:*

Doctor Roberts asked me to discuss his paper. Since coming here, however, I find that he has a distinguished guest with him who has some very pertinent data on the use of organic dyes in puerperal infections. As Doctor McKinnon is not here I will ask your indulgence to allow Dr. James R. Reinberger, Professor of Obstetrics at the University of Tennessee, possibly a few more minutes to give us some really important data on the use of organic dyes in puerperal infections.

(Motion by Dr. Hoffman that the privileges of the floor be extended to Dr. James R. Reinberger. Motion seconded and carried.)

*Dr. James R. Reinberger, Memphis:*

I can assure you that it is an unexpected pleasure to me at this time to participate in the discussion of such a timely paper. I don't believe that I could add anything to Doctor Roberts' presentation. Certainly one can't fail to note that he is at least athletically inclined, and that he has delivered one of the clearest and simplest presentations of a very difficult subject. I am going to forego anything that might have been mentioned in his paper, and will be more than pleased to give you some figures resulting from a national survey of puerperal infections.

We have been using sulfanilamide about three years. With your indulgence I would like to show you the results that we have achieved up to date. Until the time of sulfanilamide, with the exception of prophylactic measures, I was almost a fatalist when encountering a case of puerperal infection, but with this new drug I feel that we have been given the greatest advancement in the field of obstetrics, probably since the introduction of anesthesia, etc.

*Discussion while showing slides:*

I am not going to read everything shown on these slides. I am not even going into the dosage of sulfanilamide. We feel that it is something that we inadvertently fell into. Sulfanilamide is a two-way sword. Results can be obtained by wise administration; but, on the contrary, deaths have occurred from over-dosage. There has been one such death in our series since I made this preliminary report.

This slide was made in an effort to find what progress had been gained in the evolutionary treatment of puerperal infections. There were 54 cases in this series. All patients had positive blood stream infections. We called this condition a bacteriemia in contrast to the usual term, septicemia.

The series began in 1929. Treatment during that year was blood transfusion and medication. We had one case which was lost; a mortality of 100 per cent. In 1930 treatment was blood transfusions and serum. We lost that case. Deaths 100 per cent.

In 1927 we had the introduction of an antistreptococcic serum of Lash and Kaplan. Four cases were treated in this manner. That year out of a total of 7, 5 patients died. Mortality 75 per cent.

In 1928, we added additional blood to antistreptococcic serum. 7 patients were treated; 2 were cured, 5 died. Mortality 71.4 per cent.

Then, from 1931 to 1935 we had 11 cases, all medically treated in the manner outlined by Doctor Roberts, with the addition of blood transfusions. Of the 11 cases treated, 5 patients were cured, 6 died. Mortality dropped to 54 per cent.

Sulfanilamide was introduced in 1936. Six cases treated, 4 patients were cured, 2 died. But, as you will note, these 2 patients died before we knew anything about dosage, and only received 10 and 20 grains respectively. You cannot attribute these deaths to the failure of sulfanilamide.

In 1930, 13 cases were treated; 9 patients were cured, 4 died, a mortality of 30 per cent. In this particular group of positive blood culture studies, antistreptococcic serum was used. Three cases treated, 3 patients recovered. No mortality. In 1936 and 1937 we started to use sulfanilamide. Of five cases treated, five patients were cured, no deaths, mortality 0.

In the entire series for ten years 54 cases were treated; 30 patients were cured, 24 died; mortality 44.4 per cent.

You will see we have compared our figures with Colbrook, who initially sponsored the use of sulfanilamide in puerperal infections. We compared our figures not thinking we could anywhere equal his figures. However, out of 82 cases Colbrook had 56 deaths, or a 72 per cent mortality before using sulfanilamide. We had a mortality of 51 per cent. Since the introduction of sulfanilamide out of 22 cases treated by Colbrook, there were 6 deaths, or a mortality of 27 per cent. You can readily see that he dropped his gross mortality from 70 to 27 per cent with sulfanilamide. We brought our mortality down from 51 to 18 per cent.

I think this drug should be used for all types of infections, particularly *Streptococcus haemolyticus*. Methylene blue should be given intravenously for the relief of patients suffering from an over-dose of sulfanilamide. Some give methylene blue by mouth, but we prefer the intravenous method. Laboratories associated with hospitals can determine the amount of blood concentration and the oxygen-carrying ability of the blood.

In 1927 to 1937 out of 15,000 patients delivered there were 54 cases of positive blood stream infections; an average of 3.5 per 1,000. *Streptococcus haemolyticus* was found in 34 of 54 cases. Out of these 54 cases 24 patients died, a mortality of 44 per cent.

This study indicates that sulfanilamide seems to offer at least a sense of security heretofore absent. Out of the last group of cases treated with this drug no deaths occurred. We conclude that there is considerable room for improvement. A great deal can be accomplished by prophylactic measures.

Oliver Wendell Holmes says that the woman about to become a mother and the one with a newborn infant should be the object of infinite care and sympathy. God forbid that a member of this profession, upon whom rests the responsibility of those lives, should be guilty of neglect.

I want to thank you again for the privilege of discussing Doctor Roberts' paper and the pleasure of appearing before the Florida Medical Association.

*Dr. Homer Pearson, Miami:*

Doctor Roberts has presented a most interesting and enlightening study on the rules of practicing obstetrics. I think he will state to you that he has not presented anything new, nor did he intend to, but has merely emphasized those rules that we should all follow if we intend to practice obstetrics successfully. It is unfortunate that those persons who most need this discussion are not here to hear it.

I would like to emphasize again, over and over, that the thing that we need to do as practitioners of obstetrics is not to get in a rut but to practice the obstetrics that we know how to practice.

I wish to congratulate Doctor Roberts on his presentation. I don't know when I have heard one that I have enjoyed more.

*Dr. William C. Roberts, (concluding):*

Doctor Reinberger is my ex-chief. I thank him very much for his contribution. I believe he gave you something that probably you did not know, and which I am sure will be of great help.

I also thank Doctors Hoffman and Pearson for their remarks.

## FIVE HUNDRED CONSECUTIVE MAJOR OPERATIVE GYNECOLOGIC AND OBSTETRIC CASES

FERDINAND RICHARDS, M.D.  
Jacksonville

Walter T. Dannreuther has stated that in these days of aseptic technique the postoperative survival of the patient no longer constitutes a surgical triumph. Expert anesthesia and modern operating room facilities have done much to reduce the hazards of pelvic surgery. A truly satisfactory operative result implies not only conservation of the patient's life but also an uneventful convalescence and subsequent complete symptomatic relief. And, still further, the hazards of gynecologic and obstetric surgery have been reduced by the use of glucose intravenously, the use of blood transfusions more frequently, and the use of the deflation suction tube.

This series of 500 consecutive cases represents work done on my ward service at the Duval County and St. Luke's Hospitals and private cases at St. Luke's, St. Vincent's and Riverside Hospitals of Jacksonville, Florida. All of these cases were operated upon by myself or under my supervision by staff associates or resident surgeons. The Duval County Hospital, where many of these patients underwent operation, is an all charity institution. Bed space is limited. Because of economic reasons and the type of patient seen it is not always possible to render the desired preoperative service. Many patients in an extreme condition present themselves as candidates for pelvic surgery, making poor risks and offering a very doubtful prognosis. Chronic tubovarian disease, uterine fibroids, advanced malignancies, anemias and the like represent the usual, rather than the unusual, conditions. Naturally, the many hazards and disadvantages with which the surgeon is

forced to contend in treating this type of patient is increased, which in turn increases the incidence of complications and the mortality rate. Each case presented constituted a major surgical problem and practically every phase of gynecologic surgery was encountered. The obstetric cases are limited to cesarean sections.

Determination of mortality rates is a simple matter but the incidence of postoperative complications offers an entirely different problem. This cannot be done without carefully scrutinizing each case. A review of the work in this series with the idea of ascertaining the type or caliber of the preoperative study and preparation of the patient should prove whether the postoperative complications were as low as they should have been and whether the mortality rate could have been improved. Five hundred consecutive major gynecologic and obstetric operative cases are presented. There were complications during convalescence in 32 patients, an incidence of 6.4 per cent, but several patients had multiple complications and the corrected incidence is 8.4 per cent. Sixteen patients died, a mortality of 3.2 per cent. Two deaths can be eliminated, giving a corrected mortality rate of 2.8 per cent. The rate in the private cases is 2 per cent. The average number of hospital days in this series is 16.2; in the ward cases it is 27.2; in the private cases, 12.5.

### PREOPERATIVE MEASURES

Preoperative study and care of patients in these modern times is, or rather should be, well standardized. The usual measures are familiar to every pelvic surgeon, but in order to refresh your memory I will outline the methods employed in this series. A careful history is taken and a thorough physical examination is made, laboratory tests as indicated are done but, with the exception of the blood Kahn, never routinely because such practices often impose needless financial burdens on the patient. Only catheterized specimens of urine are examined. Attention is directed towards the intestinal tract to eliminate constipation and if such is found, preoperative intestinal cleansing is done. Fluids are encouraged. Symptoms pointing towards disturbances of the urinary tract are investigated.

The urologist is consulted and proper studies are made which in many instances have elimi-

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nated useless pelvic surgery, appendectomy, etc., which in reality was found to be due to ureteral stricture, pyelitis, calculi, etc. In all cases of urethritis, vaginitis, and cervicitis smears are taken. Cervical erosion, ulceration or enduration are always indications for biopsy study to rule out early malignancy. Patients with fever or other manifestations of inflammatory disease always have a complete blood count and blood sedimentation time test. The latter is invaluable as a guide in pelvic inflammatory disease. If the hemoglobin is less than 65 per cent or the red blood count under 3,500,000 every effort is made to obtain blood transfusion before operation. In elective cases postoperative transfusion should not be required except in hemorrhage, sepsis, shock or ectopic pregnancy. Attention is directed to the oral cavity. When cardiac, respiratory, diabetic, or other systemic complications are in evidence proper consultation is had. The selection of the proper anesthetic is of no less importance.

#### POSTOPERATIVE CARE

Certain cardinal principles must be understood for the proper handling of each case. One of the first considerations before the patient leaves the operating room table, when inhalation anesthesia is used, is for the anesthesiologist to flood the lungs with a 10 per cent mixture of carbon dioxide and oxygen. This may be continued for ten minutes hourly for the first twenty-four hours. In abdominal cases nothing is given by mouth for the first twenty-four hours. Morphine or pantopon is administered every four hours and fluids intravenously or subcutaneously, sometimes both, every six to eight hours for the first twenty-four hours. External heat to the trunk and extremities is applied. The heat cradle is an excellent method. These measures known to most of us were outlined by Oschner several years ago.

The bladder is catheterized every eight to ten hours if the patient is unable to void, and certainly one should have no fear of postoperative cystitis if the catheterization has been properly done. The rectal tube is used freely but carefully. Dressings are not disturbed as a rule in clean cases for seven to eight days. Drains are seldom found necessary and in most instances when needed the

vaginal route is employed. Sometimes stout women require a small rubber dam drain beneath the fat for seventy-two to ninety-six hours. The Levine suction tube is used if vomiting or distention occurs and is continued until all symptoms have disappeared. When indicated glucose solution in saline, Ringer's solution, or water is given every eight to ten hours intravenously, never subcutaneously. Normal salt solution is used subcutaneously when indicated. The use of insulin following the administration of glucose in shock cases is very beneficial. The fluid intake should remain between 3000 and 4000 cc. each twenty-four hours. Mineral oil is usually begun after ninety-six hours, night and morning. Enemata are given after ninety-six hours if found necessary but, if intestinal work has been done, due care must be exercised in their use.

In vaginal plastic cases the parts are kept dry by the use of dusting powders. The use of heat by means of an ordinary electric bulb for twenty to thirty minutes, two or three times a day, placed about 18 inches from the operative field is definitely stimulating, increases circulation and promotes healing. The bladder is catheterized every six to eight hours for three days regardless of the patient's ability to void. No douches are employed. Urinary antiseptics are given. In vesicovaginal fistula the indwelling catheter is employed for ten or twelve days and is irrigated once or twice daily with boric acid solution. Rectovaginal cases, just as in complete perineal tears, are protected by keeping the parts dry and restricting the diet to fluids and constipating the patient for seven or eight days, after which injections of warm oil into the rectum are used and mineral oil given by mouth.

#### GENERAL MEASURES

Gastric lavage is used far less frequently today than in the past. Cathartics are seldom if ever used and then only in mild forms after seven or eight days. The position of the patient is changed every few hours and she is encouraged to move the extremities as early as possible, in order to minimize the occurrence of postoperative embolism and thrombophlebitis. Should this complication arise roentgen ray therapy given in time is almost a specific. The use of antiseptics to the oral



cavity and chewing gum is encouraged which may prevent postoperative parotitis. Should this complication arise roentgen ray therapy given early is almost a specific.

#### POSTOPERATIVE COMPLICATIONS

The various complications arising in this series of cases are outlined in their order of frequency; some patients had multiple complications: urinary 16, cardiovascular 7, infected wound 6, gastro-intestinal 5, systemic 4, hemorrhage 2, pulmonary 2.

*Urinary complications.* Acute pyelitis occurred in three patients, one following complete hysterectomy, one supravaginal hysterectomy and a third-degree repair of the perineum, and the other following a cesarean section. An accompanying cystitis occurred in two of these cases but was very mild. The cesarean patient had been dismissed from the hospital and suddenly developed signs of a typical kidney colic. She was sent back to the hospital where a cystoscopic examination with pyelograms was done. A kinked ureter was found causing the pyelitis and hydronephrosis. In one patient the bladder was accidentally opened. A large fibroid was present which had pulled the bladder up to the level of the umbilicus. This was repaired and a self-retaining catheter inserted, the patient making an uneventful recovery. A vesicovaginal fistula developed in one patient on the eighth day following a complete hysterectomy, anterior colporrhaphy and perineorrhaphy. The self-retaining catheter was used and the patient made an uneventful recovery.

Two elderly patients died of suppression and uremia following complete hysterectomy. Each of these patients was seen by a competent urologist, cystoscopy performed, ureters catheterized but no obstruction or demonstrable damage to the ureters was found. However, one patient with adenocarcinoma of the fundus had an extension into the bladder which was found after the operation. Had a pre-operative cystoscopy been done this condition would have been recognized. One case of congenital horseshoe kidney was found at autopsy on the sixth day following cesarean section. This patient had marked pelvic dystocia, spina bifida and meningomyelocele. The true cause of death was ileus but doubtless the congenital kidney was the contributing factor in this mortality.

One case of multiple abscesses of both kidneys occurred following a hysterectomy for chronic tubovarian disease and multiple fibroids. The patient had been in the hospital for forty-five days. Every effort was made to improve her condition before operation. However, she became worse and surgical intervention was mandatory. There were other complications, namely, peritonitis and pneumonia.

*Cardiovascular.* Phlebitis occurred three times, one after a cesarean section, two after hysterectomy. The first two occurred several years ago, the third more recently. After roentgen ray therapy there was no visible evidence of the trouble after the fifth day. All patients survived. Cerebral embolus occurred twice following hysterectomy and once following suspension of the uterus and ligation of varicose veins of the broad ligaments. Both patients died. One patient died in twenty minutes following intraspinal injection of 100 mg. of novocaine for the removal of an ovarian cyst. Cause of death at autopsy was found to be chronic myocarditis and degenerated heart muscle. Under no circumstances should this patient have been given a spinal anesthetic.

*Infected Wounds.* Six patients had infected wounds; four occurred in clean abdominal cases. The other two occurred following third-degree repairs. Each wound healed and recovery followed.

*Gastro-intestinal.* Ileus, as a complication, occurred in one patient following a supravaginal hysterectomy for an early pregnancy. This patient also had rheumatic heart disease following scarlet fever, mastoiditis, nephritis, arthritis, congenital dislocation of both hips and ankylosis. The Levine tube relieved the condition and the patient made an uneventful recovery. Another patient had ileus following a cesarean section, the patient previously mentioned with the horseshoe kidney. This patient died. Acute peritonitis occurred in two cases following hysterectomy for tubovarian disease and fibroid uteri; both patients died. Acute unilateral parotitis occurred once, following myomectomy and suspension of the uterus. This occurred in seventy-two hours but subsided in three days following roentgen ray therapy.

*Systemic.* Postoperative shock occurred three times. One was in a profoundly septic patient following an emergency cesarean sec-

tion which was complicated by an ischiorectal abscess. This patient died one and a half hours following the cesarean section despite precautionary measures, support, etc. Another instance was in a patient ill for weeks with chronic tubovarian disease. Recovery followed. The third occurred following complete hysterectomy. After immediate transfusion and glucose the patient survived. Ventral hernia developed in one case following complete hysterectomy for adenocarcinoma of the fundus. The wound was infected and considerable necrosis and destruction of tissue followed. This was later repaired and after five years the patient is living.

*Hemorrhage.* Postoperative hemorrhage occurred twice but in neither instance was it fatal. One followed the Manchester procedure for cystocele and partial prolapse. The patient was not catheterized as ordered; the bladder became distended, breaking down the suture line and hemorrhage occurred into the broad ligaments and vagina. The wound was immediately repaired and a self-retaining catheter inserted. This complication might have been averted had a self-retaining catheter been used following operation. The other case followed a cesarean section. This patient was ill in bed for two months with an ischiorectal abscess complicating pregnancy. Uterine inertia developed one hour after operation despite oxytocics, blood, etc. Death followed.

*Pulmonary.* Lobar pneumonia occurred in one case six days after a supravaginal hysterectomy. The patient died. Bronchopneumonia occurred once following bilateral salpingectomy and unilateral oophorectomy for chronic tubovarian disease. The patient recovered.

#### SUMMARY AND CONCLUSIONS

1. Five hundred consecutive major pelvic and obstetric cases are presented. There were complications in 32 patients, an incidence of 6.4 per cent, but several patients had multiple complications and the corrected incidence is 8.4 per cent. Sixteen patients died, a mortality rate of 3.2 per cent. Deaths of two patients can be deducted for the following reasons: one was a patient who was moribund due to premature separation of the placenta and the operation was done to save the child; the other was a patient with a cesarean section who had multiple complications already men-

tioned and a congenital anomaly. This gives a corrected mortality rate of 2.8 per cent. The rate in private cases was 2 per cent.

2. The average hospital days in this series was 16.2 days; in the ward cases 27.2 days; and in the private cases 12.5 days.

3. Seventy blood transfusions were done. Postoperative blood transfusions should not be necessary except in the presence of secondary hemorrhage, sepsis, ectopic pregnancy or shock.

4. Preoperative cystoscopy and renal function tests may eliminate useless pelvic operations.

5. An indwelling ureteral catheter in complete hysterectomy should prevent injury to the ureters.

6. Pulmonary infections can be reduced by employing a skilled anesthetist and the use of 10 per cent carbon dioxide and oxygen before the patient leaves the operating table and its continuance for ten minutes hourly for the first twenty-four hours.

7. The early use of the Levine tube is the most satisfactory method for the relief of ileus.

8. Roentgen ray therapy for all practical purposes may be considered specific in postoperative thrombophlebitis and parotitis if used early.

9. Active motion throughout convalescence will reduce the incidence of postoperative phlebitis.

10. Unpreventable shock will sometimes occur in septic patients.

11. Correction of constipation by thorough cleansing of the intestinal tract will reduce the incidence of postoperative pyelitis.

12. All patients with congenital anomalies deserve a most careful preoperative study.

13. Spinal anesthesia in properly selected cases will reduce the mortality rate.

14. The use of Vitamin B<sub>1</sub> therapy has a definite place in postoperative convalescence.

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614 Greenleaf Building.

#### DISCUSSION

*Dr. C. J. Collins, Orlando:*

A review of this nature, presenting a critical analysis of a large series of pelvic operations, is always illuminating and provides food for serious thought. In this way errors of the past are discovered and progress of the future assured.



This series of cases speaks well for careful preoperative measures and good postoperative care for a mortality rate of 2.8 per cent in an unselected group of charity cases is most commendable. When one considers the large number of neglected cases seen in a charity service, the mortality rate must necessarily be higher than in a more selective series of private cases. While I have no statistics to present, I am certain this has also been our experience at the Orange General Hospital.

As Doctor Richards has said, most preoperative and postoperative measures are today pretty well standardized, but that elusive thing called surgical judgment, is not and perhaps never will be. I think the one most important thing to remember is that very little pelvic surgery is of an emergency nature. The majority of these cases provide ample time for a complete study and a careful preoperative routine. There is certainly little excuse for the surgeon who sees a patient in the office one afternoon and sends her to the hospital that night for pelvic surgery the next morning. He is the surgeon who will have the highest mortality rate. The hospital where the greatest number of cesarean sections are done is the hospital where the poorest type of obstetrics is performed. The one where operations for acute pelvic inflammatory disease are the most common, will be the one that has the highest mortality rate in its gynecologic department. I know of no type of case where greater surgical judgment is required at times than in the differential diagnosis between acute appendicitis and acute salpingitis, and it is encouraging to see the number of surgeons today who have the courage to refrain from continuing the operation when faced with "hot tubes" instead of an acute appendix.

We have the same complications and the same causes of death as Doctor Richards has reported. These can never be entirely eliminated but with a well organized hospital service, where consultations are plentiful, they can be reduced to a minimum.

Elderly women often present a serious problem for pelvic surgery. They often stand vaginal operations well but abdominal ones poorly. All genital prolapse in these women can be corrected by the vaginal route. Preliminary treatment of the vagina to clear up infection, such as the employment of the estrogenic preparations, will reduce the incidence of infection and promote healing. There are a few other measures I might mention, in addition to the sound surgical principles presented here today, that will reduce complications and lower mortality rate. The vagina should always be surgically prepared in all cesarean sections and abdominal hysterectomies. A retention catheter should be used in all plastic operations on the anterior vaginal wall. Daily irrigations with a weak silver nitrate solution and the use of urinary antiseptics will prevent cystitis. Abdominal operation is never indicated in acute pelvic inflammatory disease except for drainage in the face of a spreading peritonitis. I am convinced that the subtotal hysterectomy, except in malignancy of the uterus, will in the hands of the casual operator, carry a lower mortality than the total operation. The diseased cervix can usually be handled satisfactorily by preliminary cauterization and the incidence of carcinoma in the cervical stump is no greater than that of cancer of the cervix as a whole.

I wish to thank Doctor Richards for the privilege of discussing his paper and congratulate him upon his splendid presentation.

*Dr. Joseph S. Stewart, Miami:*

I wish to commend Doctor Richards on his review of 500 cases. We have few such presentations on our State programs, probably because of the gigantic amount of work involved. We would do well to have more reviews of operations done, and a review of 50 cases is just as valuable as one of a thousand. The reports on large series of cases, seen in the literature, discourage those of us not connected with large hospitals in thickly populated communities.

You note that only 6 wound infections are reported, 1.2 per cent, an astoundingly low incidence. I cannot help but believe that the essayist is less strict than I in grading his wounds. No mention is made of evisceration in the entire series; therefore I conclude that none was encountered. This well illustrates the greater incidence of evisceration in upper abdominal wounds rather than in the low wounds of gynecologic surgery. I doubt if any general surgeon could report 500 consecutive abdominal operations without five or more eviscerations.

I am sure all of us agree with the essayist that preoperative study and preparation is our best means of reducing postoperative complications. The study of the patient as a whole is just as important as a well executed operation, and perhaps even more important.

I am delighted to hear Doctor Richards' opinion of the great value of x-ray in thrombophlebitis. I am aware of its value in postoperative parotitis, but did not appreciate its value in the former condition.

I cannot quite agree with the essayist in his desire to completely empty the intestinal tract before surgery nor in his method of constipating the patient for seven or eight days postoperatively in rectovaginal repairs. I disturb the intestinal tract as little as possible preoperatively and if the patient has daily bowel movements not even an enema is given, and under no condition are cathartics allowed. A non-residue diet is given for twenty-four hours preoperatively, of course.

I agree that the more the intestinal tract is disturbed preoperatively the greater the incidence of ileus postoperatively.

I believe that the low incidence of complications in this series is due to the acumen of the essayist in careful preoperative care and in early recognition of complications, and thus their early treatment. The difficulty of surgery is not the operation but the judgment needed to decide what to do and the recognition of complications when they occur, and they do occur.

I wish to thank Doctor Richards for the privilege of hearing and discussing his paper.

*Dr. W. W. Harden, St. Petersburg:*

Doctor Richards has presented an excellent paper. I thoroughly enjoyed it.

As Doctor Stewart has said the treatment of circulatory complications is rather new and opens up a valuable field of research.

I would like to ask Doctor Richards if he can give us his technique, that is, as to the diet, dosage, and treatment of circulatory complications from phlebitis, thrombo-angiitis or arteritis; whether he moves these patients to the therapy room or if he gives it with a portable machine; if he can give us the technique as employed in the treatment of these circulatory conditions.

*Dr. Ferdinand Richards, (concluding):*

I appreciate these discussions. However, I have very little to add except in attempting to answer Doctor Harden.

My policy has been: just as soon as I find the thrombophlebitis to call the x-ray man and let him handle that phase of it. I am unable to state the dose of roentgen ray therapy in treating this condition; this is handled entirely by the x-ray man. I am sure Doctor Shaw or some other x-ray man could help you out on it.



## THE MENACE OF STATE MEDICINE

R. F. GODARD, M.D.  
Quincy

Progress is not automatic. The world grows better because there are high-minded souls who wish that it should, and because they will and dare to take the right steps to make it better. So we commemorate the efforts of the great pioneers of medicine who felt that the scheme of human relationship was out of balance, and capitalizing the gregarious or fellowship instinct and the altruistic desire to serve, inherent in most men, gave us organized medicine. To them we acknowledge a debt of gratitude.

Life's tale is soon told. The years, which in childhood loom large as planets, shrink fast as we journey along life's highways, and the mileposts move rapidly by. But whether we be blessed by long careers or short, there are hours enough if we but use them. No man has done enough for his fellows. We are ready for the treasures of new friendships, which make wisdom splendid, office and honors beautiful, and offer us never-ending hours of pleasure.

The finest ideals will not propagate themselves. In organized medicine we have the happy combination of ideals plus organization. An individual may worthily desire to serve and build, to imbibe deeply of friendliness, tolerance and understanding, but alone fail to impress the armored hide of indifference, selfishness, hate and bigotry. But with an organization of men similarly imbued with and fortified by an exchange of ideas, mutual helpfulness, and a splendid association which marshals for him an array of leadership, experience, facts and literature and binds all together in a perfect union, he becomes an integral part of a great altruistic force for human good.

We are a great body with maturing obligations and of recognized importance in the councils of the continent. We may be proud of the past but we grow with the years. We think of the fine and outstanding achievements of a glorious past but we consecrate ourselves to a larger future of helpful service to humanity.

The United States owes an incalculable debt

to the American Medical Association. Whatever criticisms now may be aimed at it by the idealistically minded who are shocked at obvious imperfections in the medical services available to the people as a whole, the fact remains that the organized profession itself, voluntarily and from a sense of duty, is responsible for about everything "social" in the practice of the healing arts of today.

It found American medicine in a chaotic condition. There were essentially no minimum standards of education or of competence. In most states a few years as a helper in a doctor's office or around a hospital and the passing of a written examination were sufficient to launch a man on the practice of medicine. The American Medical Association has worked ceaselessly for higher and higher minimum requirements. It has put low-grade medical schools out of business. It has made the acquiring of an M. D. degree and a State license to practice a major struggle for any man and a hopeless struggle for an individual of mediocre intelligence. The public now is absolutely assured that any man who has graduated from an American medical college and passed a State Board examination is up to a certain high standard of proficiency.

It is reasonably assured that he is not lazy or careless, unless his personality undergoes a remarkable change after leaving college, and it may be reasonably sure that he is not a scoundrel, for dishonesty hardly could get through the filter of present-day medical education, for which the American Medical Association is responsible.

The American Medical Association has waged a strenuous fight to eliminate quackery. Contemptuously defiant of slander and libel suits, it has mercilessly exposed the nonsense of healing cults and alcohol-and-water nostrums. It probably would have succeeded altogether were it not for the obstacles thrown in its way by politics. Through its local units it has rigorously punished, by censure and expulsion, violations of medical ethics. It has waged an unceasing campaign, both nationally and through these same local units for the health education of the public. By cold experimentation in its laboratories it has established the values of new remedies. It has constantly encouraged medical research, and has kept the entire profession aware of the latest advances in medical science.

Read before the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society, Quincy, October 20, 1938.

This is not the time for didactic essays or ornate orations. In these days—to use the fine phrase, “the times that try men’s souls”—the only thing that is valuable in speech is sincerity, and it is in that spirit I speak to you for a few minutes on “The Menace of State Medicine.”

Two widely antagonistic forces are striving for dominance in America. On one side is the desire and ambition of the individual to live his own life, carry his own responsibilities and secure the utmost mental and material development, while on the other is the ambition to have the people subjected wholly to *herd* ideas whether advantageous or otherwise with only an inner certitude, a personal sense, necessarily imperfect, that the way the herd is directed is also the best way. The contest is between individuality and regimentation, and while regimentation with its attendant oppression has secured high place among decadent nations of Europe it will be fought bitterly in America which has grown great through private initiative.

What is socialized medicine? Socialized medicine is a broad term. Anything is socialized which is supported by people as groups, rather than as individuals. Given many different names, it is sometimes called state medicine, which indicates medical services furnished by government employees who are paid out of tax funds. When we think of socialized medicine, we assume that it would cover everyone. In practice, it does not work that way. Most medical plans cover only industrial workers. Independent workers, such as shopkeepers, professional men, and farmers are excluded. The reason for this is that while it is easy to have the periodic contributions deducted from the worker’s pay envelope, it is difficult to make regular collections from the self-employed. In Germany, where it has been in effect since 1883, only about 40 to 45 per cent of the population are covered. In Great Britain, where the practice began to be operative in 1911, 39 per cent are cared for.

We next come to the question of how much it would cost for the individual to be cared for under such method as this. The Michigan State Medical Society spent \$15,000 in an investigation to obtain this information. For the purpose of administering the plan, the Michigan committee estimated that the average family consisted of 4.1 members and set \$118

as the tentative fee for the average family whether it has two members or a dozen. Contrasted to that, the average cost per family today actually is \$62 under our present system of medical care. The Committee on the Cost of Medical Care which began its studies in 1928 and completed them in 1932 consisted of 48 members. They published 28 major reports and a number of miscellaneous pamphlets dealing with medical care and its costs. This committee showed that 90.2 per cent of the people who are ill at any one time receive medical care. The other 9.8 per cent is easily understood when we consider the fact that approximately 50 per cent of the illnesses in this country are common colds or other bronchial ailments, and that many people feel they are not ill enough to need a doctor. Also there is a certain proportion of persons who, for religious or other reasons, will not consult a doctor under any circumstances. Those who argue most for controlled medical care are largely the sociologists, the Socialists, and a scattering of promoters whose discontent obscures their appreciation of the value in the present system.

Recent investigation by the Bureau of Medical Economics of the American Medical Association proved conclusively that there are few, if any, in the United States really suffering for want of medical care. The mayors of cities of various sizes testified that there was no neglect of the poor because of their inability to pay. Those who argue that people are not taken care of ignore the fact that doctors always base their charges on the ability to pay and are willing even to carry this policy to the rendering of free service to those who need it.

It is significant that the Committee on the Costs of Medical Care made no attempt to show how many sick people sought and were denied medical care because of poverty. The reason is that there was practically none. J. Weston Walsh, in compiling a handbook on state medicine, addressed questionnaires to physicians and public health officials the country over. The reports were practically unanimous that few, if any, are denied proper care. It might be asked: Is such free service as is now available degrading to the poor? We have every sympathy for the poor who wish to maintain their self-respect. Yet in viewing this matter it is necessary to perceive



a sense of proportion. No one has yet suggested that the state take over the farms and factories and provide everybody with food and clothing merely to save those unable to pay from feeling that they are accepting charity. A little sympathy for the doctor may not be out of place. Nobody ever heard of a grocer reducing prices to those unable to pay, but a doctor does. The trouble is that many people regard a sickness as an accident for which they are not to blame, and therefore they do not feel the obligation of medical bills as much as the obligation of installments on the radio. They should be educated to understand that illness is to be expected. The costs should be prepared for and, in justice, paid as promptly as other bills. The Michigan State Medical Society found that the annual expenditure of the average farmer's family for physician's care (considering a family as 4.1 people) is \$62. The family tobacco bill is more than the farmer's family doctor bill. Twice as much is spent for candy as for hospitals. Twice as much is spent for cosmetics as for nursing.

When it comes to costs, let me remind you of a comparison in the United States Army. The Army is a picked group. Each man is selected because he is healthy. We would naturally expect this group to have the smallest per capita medical cost in the world, but John R. Neal, M. D., writing in *Clinical Medicine and Surgery* for March, 1935, declares that the Army medical system costs just double the average per capita medical costs for the United States. This was confirmed by the Committee on Costs of Medical Care itself when it found that Army medicine at Fort Benning cost just \$50.67 a person, or the equivalent of \$200 a year for the average family of four.

America is now leading all other nations in the extent and quality of her medical research. Perhaps this is due to the fact that physicians in other countries have not the time to carry on such work. The profession is not fighting socialized medicine to preserve its own existence, though it could be pardoned if it were. It is fighting to keep the hands of the politicians from controlling the practice of medicine to the detriment of the health of the American people. It is fighting to prevent a gross bureaucracy from wedging itself between doctor and patient. Dr. C. B. Read,

former president of the Chicago Medical Society, clearly stated the opinion of the medical profession when he said: "The State cannot manage without commanding, and it will happen, therefore, when the State assumes authority, that our profession will fall under the thumb of the politician. The dictation to the doctor by the lay boards in certain medical institutions is bad enough, but such dictation becomes insufferable when exercised by self-seeking ward heelers and ruthless political organizations."

Medical care has been classed as a necessity by the national government. Not so very many services are given that high rating, and all services so rated cost a good deal of money. We hear so much distressful talk about the suffering of the under-privileged and the indigent because of the high cost of medical care. These two unfortunate classes have but little money in any event, and there can be no doubt that they suffer from lack of some of the other necessities as well. Those who propose a change in our system of practice make no provision whatsoever for these people; they are still left to the practice and charity of the private practitioner of medicine, because the beneficiaries of state or socialized medicine must have steady jobs or some other effective means of contributing to the massive coffers required to pay the expenses of the system. So in discussing the cost of medical care we are justified in leaving out of consideration the underprivileged and the indigent, because they are now cared for without cost by private practitioners. Leaving out of consideration these two classes, the people of our nation are not so poverty stricken.

We are advised to turn from the system of private practice to some form of socialized or state medicine; to follow the lead of Germany and England. We crossed the ocean once to get away from the lead of European countries, and by adopting different customs and laws, built here the greatest civilization in history.

Germany has had state medicine for more than fifty years; it was introduced there by Bismarck, as a political measure and not in response to public demand. It was introduced into England by Lloyd George as a political measure. Lloyd George promised the industrial workers that he would give them two dollars and a quarter in medical care and cash



sick benefits for every dollar they contributed—the “something for nothing” that the people have always sought. No form of socialized or state medicine has ever been proposed seriously that did not offer its beneficiaries a good deal more than they paid for; some have thought this to be the secret of its popularity, the strong argument in its favor. The various types of socialized medicine follow pretty well one pattern. The employee pays a certain percentage of his wage into a fund, the employer pays a certain percentage of his pay-roll into the same fund, and the balance is provided by general taxation. The fact that taxation provides a part of the money to defray the expense of socialized medicine places the system pretty well under the influence of politics, and the politician is seldom trained in medical matters.

The beneficiary of socialized or state medicine receives medical care—not complete, under most systems—and cash benefits when he is sick and not able to work. Since his doctor bill is always paid, he is supposed to feel very free about consulting the doctor. That is one of the strong points urged in favor of the system. There may be some defects that do not become apparent until tried, but the point of interest is: does socialized medicine provide better medical care than is provided by the system of private practice? If it does, if under it prevention of disease is better carried on, early diagnosis promoted, the burden of medical cost less and better distributed, morbidity reduced, mortality from disease lessened and the span of life more rapidly lengthened, then it would be fair to conclude that our system of private practice should be replaced by one of the systems of socialized or state medicine.

It is conceded that the beneficiaries of socialized medicine consult the doctor in very large numbers; it is also conceded that the majority of them seem to have minor and imaginary ills, that a surprisingly large percentage of them consider themselves too sick to work and, therefore, entitled to draw sick benefits during their period of disability. The cash benefits that are paid during sickness sometimes make a severe strain on the treasury and lead to investigations by the business department of the system. That is a source of much trouble, not only to the doctor but to

the person who feels entitled to the benefits. It is sometimes considered necessary to send out the consultant of the business department to see if the doctor in charge can be persuaded to cut off some of the beneficiaries and the business department usually has ways of doing this in spite of the judgment of the doctor in charge of the case.

State medicine goes in very strongly for record keeping. After the doctor has cleared his waiting room, he must spend much time, as a rule, filling out the large number of blanks provided by the statistical department. This is the time which the doctors who practices private medicine usually devotes to reading his medical journals or his textbooks, which is one of the chief means of keeping up with advances in medicine.

In the United States, under private practice, the industrial worker loses from eight to thirteen days a year from sickness; in Germany, under socialized medicine, the industrial worker loses from fifteen to thirty days.

Politics enters more or less, often more, into the management of socialized medicine. It does not promote the practice of preventive medicine. Its diagnostic service is inferior, and morbidity rate is greatly increased, and the mortality from nearly all of the important diseases is greater than under private practice. In no other country of comparative size and population is the average length of life quite as long, nor is it growing quite as rapidly, as in the United States.

Under the system of private practice as it exists in this country, there is one other feature which, in the opinion of most doctors and most patients, adds greatly to the service rendered—the personal relationship which exists between the doctor and the patient. It has become fixed in the customs of our people and it will continue until changed or destroyed by law. One well trained doctor may be as able as another to apply the truth of science in the treatment of disease, but times come in the life of each one of us when the cold facts of science do not avail. The personal side of the practice of medicine, which has always played an important and comforting part, steps in at such times and renders a service which the people not only desire but demand. Sympathy, kindness, pity, and cheerful hope

—no amount of scientific efficiency can take the place of these in the dark hours of sorrow and trouble so common in the experiences of all. President Eliot of Harvard said: "In these intangible things are found the durable satisfactions of life; fame dies and honors perish, but loving kindness is immortal."

I would not belittle the importance of science in medicine—I bow in humble reverence before its beneficent power, yet I know from experience what comfort, hope, and assurance the personality of a trusted physician may bring to the bedside of his patient.

Socialization tends to destroy personal service; it places all of the emphasis on the scientific side, and while the scientific side is the greater, yet divorced from the personal element it is immeasurably weakened. Our system of private practice blends the two into one service, and thus the medical care received by the American people is the envy of the rest of the world. In no other nation has medicine wrought so well in bringing health and happiness and length of days to the fleeting span of life.

Recently Dr. Frederick L. Hoffman, statistician for the Prudential Life Insurance Company of New York, and probably the outstanding medical statistician in the world, made comparison of the mortality rate of some of the leading causes of death in England, which has a system of socialized medicine, with the mortality rate from the same diseases in the United States, which still has a system of private practice. I will mention quite briefly a few of these comparisons. In England the death rate from tuberculosis of the lungs is 63.5 per hundred thousand; in the United States it is 51.2. In England the death rate from cancer is 156.3 per hundred thousand; in the United States it is 106.3.

The complaint against the cost of medical care under our system of private practice made by the advocates of change is that it is too high. No one has ever argued that medical care is not expensive, and that it does not sometimes fall with more or less crushing effect upon the unfortunate—but, other misfortunes have a way of doing the same thing. It is rather certain that socialized medicine is able to distribute the cost of medical care in such a way that the burden is not so keenly felt by the beneficiary, but the cost to society, which is the true index of cost, is very much

greater. The business set-up which looks after the distribution of medical care in socialized and state medicine, employs a great many people—inspectors, bookkeepers, supervisors, and so forth, and these must receive a living wage.

Take, for example, Germany. In 1935, there were 36,000 employees of the non-medical personnel, and only 30,000 doctors. The politicians are supposed, in theory, to keep their hands off the business and professional set-up of socialized or state medicine, but where they vote a considerable part of the money to pay the expenses of the system, they are naturally interested in the management. Sometimes they take quite a bit of interest in it. In one European country, several thousand doctors have been deprived of the privilege of practicing medicine for the state because they incurred the displeasure of the political powers. Politics is intimately bound up with the administration of socialized medicine in all cases where the state is called upon to pay large sums of money for its support, and no one should expect it to be otherwise.

Government participation in medicine should be restricted instead of enlarged. Mindful of the medical profession's ageless and fruitful tradition of self-sacrificing service and of American people's stake in personal freedom, government should refrain from competing in or monopolizing the field of medicine. If the governmental agencies will keep hands off, the medical profession will work out the problem along lines based on American ideals.

I have been following a quarrel between the Group Health Association and the District of Columbia Medical Society. How can any group of people who are capable of earning between \$1,400 and \$2,000 per year be so deluded by a plan that promises better medical care for \$2.20 per year. G. H. A. boasts that it pays its doctors \$6,000 a year. How many persons must join in order to pay one doctor's salary? At least 2,713 persons. This does not include medical equipment, expendable supplies, office space, utilities, and assistants. Hence, the number will run well over 3,000, and these 3,000 will consult a doctor many more times than they would if they were paying by the visit. The present ratio is 300 patients per doctor. Therefore a G. H. A. doctor will have to take care of 12 times as



many people as the community doctor now cares for. How can he give each patient the time and care he needs when good medical care is a long, drawn-out process and cannot be done in a few minutes? At the present time because the experiment is on trial, those doctors who have accepted such positions will do their utmost to satisfy all patients until it is on a running basis, in order to insure a salary they could not possibly equal otherwise. Personally, I feel that patients get better care by going to a doctor who can give them his time and personal attention, a man who is familiar with their family and history. One certainly gets what one pays for, and one can't expect much for \$2.20 per year.

It has been argued that the middle class will now receive the care it needs, but from personal experiences over a long knowledge of many good doctors, I know that the community doctor has always given such care, at a price commensurate with the patient's ability to pay.

A woman who is employed by the H. O. L. C. recently told how good this plan would be for people in her circumstances; yet her husband and her three grown children are employed; they own a beautiful home in a nice section of the city and own a car. This is the type person that Group Health will cater to.

The community doctor does a great deal of charity. The G. H. A. doctor will do none. Yet he throws the entire burden of charity on the community doctor and at the same time robs him of part of his income. Perhaps this is the reason he accepted such a position in the first place. He stands to lose nothing and at the same time receives at regular intervals an adequate salary, something the community doctor never has had. This type of doctor is not the type who would give his patients the best care, and couldn't if he wished.

And what will these members of Group Health, who are being intimidated into joining or going into it because it is a cheap way out, do in times of the year that are most conducive to sickness or in time of epidemic? Perish—like flies—because it is a cheap way out.

If the government could not administer medicine any better than it administers its various bureaus, if it indulged in the waste in medicine that it indulges in administering its

various functions, if it had as little regard for ability in its doctors as it has in its servants, I fear that the health of America would be in serious jeopardy. Everyone knows, or should know, that political appointments are often made for political expediency and not because of ability; and have no reason to believe that it would be any different in Federal medicine.

Some have pointed out that 430 doctors revolted against the American Medical Association in favor of Federal medicine. A splitting off of 430 men from an organization of 106,000 members cannot be called much of a revolt and, especially not, when we see that these men are not true family practitioners. Most of them are practicing on salaries in institutions and do not come in very personal contact with their patients; therefore they are not representative of the American family doctor.

Under Federal medicine, the doctor-and-patient relationship would exist no longer. The doctor's duty would be to the State and not to the patient and this astounding and unAmerican utterance is not my statement, but the statement of one close to the administration. By serving each individual patient well the doctor is performing a greater service to his country than by serving some bureau.

The 6 per cent indigent are now being well attended by the various cities and towns. Ninety-four per cent of the population are able to pay and probably wish to choose their own doctor. The agitators for Federal medicine have not proved that there is any need for such legislation. Let them prove their case and not go off on a tangent, and then be compelled to beat a hasty and ignominious retreat as they have been doing for 5 years.

The American people are a proud people and do not wish some political bureau to enter their home life, to administer their routine in illness, to invade their right of privacy. Federal medicine would be a tragedy for the American health record—the best in the world.

By means of a calm and dispassionate marshalling of facts let us redouble our efforts to convince the public that socialized medicine is "poorhouse medicine."

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*Key Bldg.*



## JELLYFISH AND PORTUGUESE MAN-OF-WAR STINGS

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Physicians practicing along the coast line, especially along the Gulf Stream or the Gulf of Mexico, are frequently called to see patients who have been stung by jellyfish or the Portuguese man-of-war. Usually the sting is not severe and the patient is soon relieved by symptomatic treatment. However, at times the patient will exhibit alarming symptoms, and there have been cases reported which resulted in death, indirectly due to the jellyfish sting, or "shock." There seems to be some difference of opinion among physicians as to the nature of these stings, and there is little to be found in the literature which deals with the treatment. The purpose of this discussion is to correlate some of the facts known; and to stimulate interest in the treatment of these stings, which may be trivial, but at times may be of grave importance. To the student of biology, the mechanism and nature of the stings have been well known for some time, but this information is not well disseminated among the general practitioners of medicine.

### CLASSIFICATION

In this locality we are concerned more with the Portuguese man-of-war, but occasionally by other jellyfish stings. Just what are these animals? They all belong to a large phylum of aquatic animals, the coelenterata, which is the basic phylum of invertebrates. They are distinguished by the presence of a mouth opening into a primitive digestive cavity, with other specialized body parts which are coordinated by a simple nervous system. Of these coelenterates, only the smaller medusae, *Aurelia*, *Cyanea*, and the *Physalia* (which is the man-of-war), are dangerous, and are to be considered.

The *Physalia* and small medusae belong to the class Hydrozoa. The *Hydra* is the simplest individual of this class of coelenterates, having an entoderm and ectoderm, and a digestive tract or enteric cavity. The mouth is surrounded by a circle of tentacles which are surrounded by nettle cells or "stinging" cells

—known scientifically as nematocysts. The nematocysts are the stinging cells common to all jellyfish and the Portuguese man-of-war. The *Hydra* reproduces by developing sexual organs on its body, both male and female, which liberate sperm and eggs. Furthermore, the *Hydra* may produce asexually by forming buds on their bodies which break loose as separate individuals. Other of the more complex Hydrozoa form in colonies of *Hydra*-like individuals which are organically connected, and these may reproduce by forming special buds which are called medusae.

The medusae become separated from the colony and float away as independent free-swimming individuals; they are essentially sexual polyps which float away to disseminate their species. These floating medusae are commonly called jellyfish or sea-nettle, depending on the species, and have the appearance of a white placenta without the cord. Some species may develop tentacles. This change from an asexual colony to a sexual individual is referred to as Alternation of Generations. Furthermore, some of the Hydrozoa develop specialized body parts which take up certain functions so as to make a physiological division of labor. Some of the polyps become nutritive, some tactile, some reproductive, and so on; which is referred to as Polymorphism. The Siphonophora, an order of the coelenterates, give remarkable examples of Polymorphism and Alternation of Generations. These Siphonophores occur as free-swimming colonies of hydroid individuals suspended by a float, called pneumatophore. The float is an example of the division of labor taken by one individual, while others, which are suspended from it, take on nutritive, tactile, reproductive, and protective functions. The man-of-war is a species of the order Siphonophora. Thus, *Physalia*, or the Portuguese man-of-war, is merely a hydroid colony, floating about with its specialized air-filled bag, or float, with a sail-like crest, from which are suspended a large number of polyps. These individual polyps are very diverse in that some are nutritive, some tactile, some male or female reproductive polyps, and some form long tentacles which contain the batteries of nematocysts or stinging cells.

The second class of coelenterates is the Scyphozoa, which are chiefly large medusae.

Read before the Second Annual Meeting of the Southeast Medical District, Ft. Lauderdale, October 13, 1938.

Among these are the Aurelia, a saucer-shaped jellyfish; and the giant, Cyanea, which may attain the diameter of eight feet. These differ from the Hydrozoa in that they have an excessive development of mesogloea between the ectoderm and entoderm, forming relatively thick bodies. These likewise develop tenacles which are studded with nematocysts and are capable of producing distressing stings. Other coelenterates are found in the third class, the Anthozoa, which includes the Sea-anemones and Corals. Of this class the Metridium is characteristic, and it also may produce severe stings.

#### LITERATURE

In reviewing the literature, one finds that death due to acute jellyfish poisoning is rare, and when it does occur, it is usually because of some other fundamental disability. H. W. Wade reported a case in the Philippines where death followed a jellyfish sting in a very few minutes. The victim was a well-developed healthy young man who was working in a mangrove swamp. He quickly collapsed, had difficulty in breathing, and died before he was brought to the shore. An autopsy revealed the livid markings on the skin ascribable only to the large, long tentacles of a jellyfish. The lungs were distended and contained much frothy, serous material that escaped into the alveoli. The right heart was full; the blood, thick and dark. The viscera were congested, especially the kidneys, which showed parenchymatous injury and albuminous material in the glomerular capillaries. Definite evidence of status lymphaticus was also found, so death was ascribed to acute jellyfish poisoning with sudden death in status lymphaticus.

Still reported several cases in the Philippines which were characterized by marked congestion in the respiratory tract, all of whom recovered.

Allen reported a case on York River, Virginia, in which intense coryza, local skin irritation, and pain were the chief symptoms. Morphine was necessary for relief.

Five cases were reported on Coliwyn Bay, in which the symptoms varied from extreme restlessness and emotional disturbances, to varying degrees of collapse and muscular spasms.

Old has recorded nine cases of severe stings which resulted from the Dactylometra (another of the Hydrozoa). These showed discomfort and pain locally, prostration, incessant cough, rapid embarrassed respiration, mucoid sputum, congestion of the face and respiratory mucous membrane, nausea, anxiety and extreme restlessness. Symptoms were of two hours or more duration and were controlled by morphine.

Crutchfield of Galveston reported several cases of dermatitis produced by the Portuguese man-of-war and described in detail the lesions produced.

#### PHYSALIA OR THE PORTUGUESE MAN-OF-WAR

This Hydrozoan is indeed a beautiful animal. It floats on top of the waves and has the appearance of a brilliantly colored purple balloon, tempting children at the beaches to pick it up. But lurking underneath the water are the long central tentacles. As soon as the tentacles are touched, they tend to coil around their prey; at the same time the nematocysts are stimulated to discharge their little barbs and inject their chemical toxin, known as hypnotoxin. The tentacles vary from six inches to several feet in length and are themselves jelly-like in nature. The nematocyst cells are studded along the tentacles at intervals. The histology of these cells as described by Zieman is as follows:

"The nematocysts arise from the interstitial cells and lie on an epitheliomuscular base. The interstitial cells of the tentacles are the parent cells for the nematocyst. The nematocyst is a pear-shaped cell with a peripheral nucleus and it is apparently hollow, but in reality it is filled with a clear fluid. Inverted and suspended in this fluid with attachments to the upper pole of the cell, is a coiled, thread-like tube with barbs at its base. Protruding above the cellular epithelium is a small, trigger-like process directly associated with the inverted barb. This trigger, when struck, varies the internal pressure of the cell and produces an expulsion and eversion of the coiled, thread-like tube and barbs, which penetrate the skin of the offending victim."

The whole nematocyst may become attached to the skin and is often found hanging on the skin of the patient. The nematocyst is thought to be a defense mechanism, but it also



assists in paralyzing and capturing small prey as food for the jellyfish. However, there are frequently seen small sergeant fishes which swim close to the tentacles of the man-of-war so as to be protected from their enemies. The nematocysts can be made to discharge their barbs in the laboratory, by the addition of acetic acid. Other forms of jellyfish likewise have tentacles which harbor the nematocysts, while other medusae carry nematocysts on their bodies and these may be found on their under surface in an area surrounding the mouth or opening into their enteric cavity.

#### TOXICOLOGY

The hypnotoxin released by the barbs which are discharged into the tissue of the victim is a chemical substance whose structural formula is not known. However, it acts as a poison, paralyzing small animals and producing a local irritation. Large doses of hypnotoxin cause severe and prolonged effects in man. Mayer Bodansky of the University of Texas, in a paper published by Crutchfield, submits the following report of his study of the so-called hypnotoxin:

"Extracts of the tentacles injected into pigeons are known to produce somnolence, decreased irritability, a lowering in temperature, and finally death, due to respiratory paralysis. The application of the tentacles or of their preparations to the skin, produces a local irritation within thirty to sixty seconds. Severe injury due to contact with the tentacles of the Portuguese man-of-war is usually followed by an elevation in temperature. Dried tentacle preparations retain their activity for long periods, one such preparation having been found active after two years. On the other hand, the poisonous properties of the tentacles may be destroyed by heat or by the action of trypsin. This would indicate that the toxic effects may be due, at least in part, to a protein-like substance. In a number of related species of coelenterates, similar physiological effects are attributed to a so-called hypnotoxin. This substance is likewise destroyed by heat. It is precipitated by alcohol and is non-dialyzable."

According to Zieman, hypnotoxin is believed to be present in other animals, even in man. Whether it is of a similar chemical structure has not been determined. It is be-

lieved that this special toxin is formed during waking hours, finally accumulated in sufficient quantity to inhibit the activity of the cortical cells and produces sleep. This theory has been supported by Pieran in his work with dogs on artificial insomnia.

Hypnotoxin seems to require the presence of a moist medium in order to produce local irritation. After removal from the water the tentacles seem to diminish in their stinging property. Bennett reported that a handkerchief used to wipe off the tentacles retained its stinging effect weeks afterward when dampened.

Since hypnotoxin is a protein-like substance it can likewise cause an allergic reaction, and sometimes following a sting the patient will exhibit a true urticaria.

#### SIGNS AND SYMPTOMS

Apparently the symptoms produced are dependent upon the area of surface involved, the length of time the tentacles are in contact with the skin, and the absorption of hypnotoxin. The symptoms may be divided into local manifestations or dermatitis, and constitutional symptoms which are due to the absorbed toxin. Immediately upon contact with the tentacles the patient feels a sharp sting or "shock," described by some as though they had touched a live electric wire. Other local symptoms follow immediately, the patient complaining of a burning and stinging in the skin. This is followed by a sense of numbness running up the extremity involved, which may be followed by an ache in the axillae or groin. Constitutional symptoms follow within ten to fifteen minutes. Nausea may ensue, and often a severe backache may follow. The patient may become very irritable and emotionally disturbed. Some individuals are reported to develop severe abdominal cramps with a rigid abdomen. Other patients may develop coryza, with a feeling of constriction in the chest. Children frequently grasp the tentacles, and they cry, rubbing their eyes; this is followed by the development of acute conjunctivitis.

The skin lesions as described by Crutchfield are well known to most of us. At first there is an area of hyperemia which conforms to a linear area corresponding to the tentacle. There usually forms along this line a number



of wheals which may reach the size of bullae. Occasionally petechial hemorrhages may form on this area and the vesicles and bullae may become bloody. Coagulation necrosis may occur and involve all layers of the skin, and secondary infection may follow. On healing, there may be a pigmented stria left along the area, which is due to hemorrhage per diapedesis. The pigmentation may last for months, but usually disappears after some time.

There is on record at the St. Francis Hospital, Miami Beach, a case treated by Dr. Frank Voris which presents another interesting feature of these stings. The patient, E. W., was admitted because of a severe man-of-war sting with vesicle formation on the hand and body, and complaining of a severe backache. Wet ammonia dressings were used locally, and opiates for pain. Two days later it was noticed that the tissue of the man-of-war which had adhered to the skin was growing and heaping up on the vesicles. No microscopic examination was made of the tissue removed, but it is possible that the animal tissue was growing by asexual budding.

The chief difference between jellyfish stings and the man-of-war stings is that the latter are more severe. Jellyfish stings seldom produce severe constitutional symptoms unless it is one of the larger medusae or the *Cyanea* that stings the victim. The smaller jellyfish cause crops of small papules where they come in contact with the skin. Locally they may cause severe itching and burning, but the shock-like sting is not so marked as seen in man-of-war stings.

#### TREATMENT

There is no definite routine of treatment which has proved satisfactory in these cases of man-of-war stings. Each doctor seems to have an individual method. Ammonia is almost a universal remedy applied by life-guards and physicians, but my experience is that this does not relieve pain nor soothe irritation. Most patients I have seen have already tried ammonia before consulting a physician. Sometimes the ammonia causes a severe burn which only aggravates the condition. Zieman reports that the practice of the natives of applying wet sand to the affected area apparently increases the local

irritation, as the hypnotoxin requires a wet medium to act. He suggests immediate drying of the affected area and applying dry pressure for the relief of pain. Doctor Crutchfield reports relief of pain by the use of a thin paste of bicarbonate of soda, followed on the second or third day by wet compresses of boric acid solution. Other colloquial remedies are gasoline, kerosene, calamine lotion, tobacco juice, etc.

It seems that the treatment of these stings should be directed at three primary considerations: first, to remove all adherent nematocyst cells and the jellylike tissue which are present; secondly, to relieve local irritation, itching and stinging by application of soothing lotions; and finally, to relieve the constitutional symptoms according to their severity.

The areas involved should be dried immediately after the sting and pressure applied to relieve the pain. Then on consulting the physician, if any foreign matter is present, the area should be thoroughly scrubbed with harsh soap, such as tincture of green soap, to remove any nematocysts which might still be adherent. Alcohol should then be applied, as suggested by Old, to precipitate any of the hypnotoxin on the surface not yet absorbed.

The local irritation will be present for several days, and itching may be the most prominent symptom. For this, calamine lotion with one per cent phenol is satisfactory. I have used with satisfactory results the following white lotion with 50 per cent alcohol:

Liquor carbonis detergens	3 i
Glycerine	} aa.
Zinc Oxide	
Alcohol	3 iv
Rose water q. s. ad.	3 viii

Sig: Apply locally for itching.

The following brown lotion with 50 per cent alcohol is also very satisfactory:

Liquor carbonis detergens	} aa.	3 i
Spirits camphor		
Tr. benzoin comp.	} aa.	3 i
Glycerine		
Alcohol		3 iv
Witch Hazel q. s. ad.		3 viii

Sig: Apply locally for itching.

For cases where large bullae form and secondary infection ensues, wet compresses of boric acid should be used. In mild irritations, proprietary anesthetic ointments, such as nupercaine, pontocaine, butesin, picrate, diothane, etc. are satisfactory.

For the relief of constitutional symptoms, codeine and morphine may have to be used. For severe pain and anxiety morphine Gr.  $\frac{1}{4}$  is necessary, while milder cases will respond to codeine Gr.  $\frac{1}{2}$ . For nervous symptoms, phenobarbital Gr.  $\frac{1}{2}$  can be used. Empirin tablets containing codeine Gr.  $\frac{1}{2}$  are prescribed every four hours until relieved.

It seems that for muscular spasms and rigidity which are sometimes present following man-of-war stings that the use of calcium gluconate, 10 cc. of a 5 per cent solution intravenously, should be of value. This has been reported to give striking results in cases of spider and scorpion bites where a similar toxin is absorbed, and in these cases the symptoms are very similar to those produced by man-of-war stings. This treatment has not been evaluated by proper controls, and should prove a good problem for clinical experimentation.

In severe cases where the patient is in apparent shock, and these are occasionally seen, adrenalin and other stimulants may have to be used.

In conclusion, I would like to raise a question for further consideration. We have a condition present in southern waters during February and March which causes bathers considerable discomfort. It usually occurs at the time when jellyfish or the Physalia are present in large numbers; more often after high seas and winds, and at times when the beaches are full of seaweed. The condition is sometimes referred to as Caribé, others call it "bathers' itch."

Jellyfish tentacles are often found scattered among this seaweed. The condition is characterized by the formation of maculopapules on the skin, usually conforming in pattern to the area covered by the bathing suit. This eruption causes much itching and stinging. It has been attributed to everything from sea-lice to allergy. Possibly this condition might be accounted for by nematocyst-like cells which grow on the bodies of the Hydrozoa, and are broken loose by rough seas to infest

the water. It is known that the nematocysts retain their stinging properties when separated from the individual, and could account for this obscure skin condition. It may be an allergic reaction of the nematocyst-infested water which is held to the body by the bathing suit, forming more or less of a patch test. At any rate, our tropical waters hold many interesting facts which should be of interest to the medical profession.

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#### PRESENT STATUS OF CANCER THERAPY

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Cancer has been known since antiquity, and many and varied were the explanations of its cause. Cancer therapy at this time was as bizarre as the explanation for its being. In the main, therapy which was successful was in the earliest cases of skin cancer, and destructive measures such as pastes, escharotic solutions, and actual cautery were used.

The true nature of cancer, however, was not apparent until the invention of the microscope made possible the study of cell structure and such pathological changes as may occur in the cell. Means of spreading or metastasizing of tumor cells was worked out, and the relationship between the structure of a cell and its propensity for metastatic transplant was recognized. Broder's classification of tumors is the final development of this

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study. The latest great step in the study of the cellular pathology of malignant tumors is the recent work upon the pathology of living tumor tissues. This study has been made in motion pictures and startling discoveries as to the actual motility of these cells have been made. After seeing these motion pictures one wonders why metastases are not more frequent.

Treatment of cancer has been influenced materially by the knowledge passed on to us by the pathologist. Thus we find that simple excision, application of rodent pastes, cured only a small percentage of the cases. As our knowledge of pathology became more exact, wider and wider excision was resorted to, and each enlarging of the surgeon's scope cut a small percentage off the expected mortality, such wide excisions being made in the hope of eradicating the entire cancer bearing mass. Also, in the light of our knowledge of pathology, it became evident that reliance upon cancer pastes was not sufficient—that even one cell which has spread beyond the limited scope of the paste was sufficient to eventually cause death. Pastes and escharotics are therefore no longer accepted methods of treatment.

The discovery of the roentgen ray and the attempt to find therapeutic applications of this mysterious force soon showed that it had a destructive effect on most cancer tissue out of all proportion to its destructive effect on the surrounding normal tissue. The discovery of the roentgen ray was followed shortly by the discovery of radium by the Curies. The effect of radium upon cancer tissue was shown to be almost identical with that of the x-ray. These two discoveries were hailed enthusiastically from all corners of the earth: "At last we have a cure for cancer! It is simply necessary to administer a dose of this unknown radiation of a size which will be within the limits tolerated by normal tissue, and cancer tissue must therefore be killed." X-ray and radium therefore became more and more widely used. Two schools of thought arose—one surgical, and one radiological, and long were the arguments pro and con. Then in an attempt to amass statistics in order to draw some definite conclusion, the fact that people who had cancer were dying in as great a number as before, took the wind out of the sails of the radiologist.

Realizing that they were fighting a common enemy, close collaboration between the radiologist and the surgeon was obtained, until today there are very few cancer patients who have not been subjected to both surgery and radiation therapy. The surgeon explained his failures by the fact that in some cases he was unable to excise enough of the tissue to wholly eradicate the last remaining cancer cell. The radiologist explained his failure by the fact that frequently there was some normal tissue intervening between the tumor and his source of radiation, and so an attempt was made to increase the amount of radiation that could be sent into a given mass of tumor tissue lying deep within the body.

The study of the absorption of x-ray by tissue was begun and machines for producing rays which were less likely to be absorbed by this overlying tissue were designed. One of the most important additions to the armamentarium of the cancer therapist was an instrument which could accurately measure amounts of radiation. Depth dosages could be determined, and their relationship to the total radiation given a surface could be computed. It was found that harder rays were less likely to be absorbed by intervening tissue, and the gradual trend was toward harder and harder x-rays. The hardness of x-rays being dependent upon the voltages exciting the tube, machines were designed to give higher and higher tensions. About 1918, machines of approximately 200 kilo volts, together with tubes which could stand this pressure, were put on the market, and for the most part, x-ray therapy in cancer has been limited to the output of this type of machine.

Within the past several years x-ray machines activated by a current under a pressure of over a million volts have been built. Several manufacturers are supplying machines of 400,000 volts and they are coming into fairly general use.

The discovery of ores high in radium content lessened the cost of radium to a point where it was possible to build bombs capable of giving a dose of gamma radiation of a size comparable with that emitted from the x-ray tube, and long range radium therapy is being practiced in an attempt to increase this so-called depth dose. Although it is too early to draw any definite conclusions from this so-



called super voltage radiation therapy, it is impossible to obtain any considerable increase of depth dosage over the dosage realized by 200,000 volt machines. This increase is certainly less than ten per cent. Other research workers have discovered that not only does normal tissue succumb to radiation only after a higher dosage than is lethal to most tumor tissues, but that normal tissue can recover from a sub-lethal dose more rapidly than can tumor tissue, and so enormous total dosages given over a protracted period seem to emphasize this difference of susceptibility.

Each of these new advances has further cut the mortality from cancer and, on the whole, we are able to show that a majority of cancer patients can look forward to recovery. This mortality can be further cut down if the physician keeps his mind open to the possibility of the cancerous nature of all chronic lesions, and early resorts to biopsy. The ardent co-operation of the surgeon and radiologist is essential. At the start cancer has no metastases, and cancer can be cured if it is recognized early, and treatment immediately instituted.

However, with all the refinements of treatment, such as accurate measurement of dosage, repeated sub-lethal doses over a long period of time, and the whole-hearted co-operation between the surgeon and the roentgenologist, the fact remains that patients are dying of cancer, no matter how adequately and thoroughly they have been treated. An enormous group of patients suffering from types of cancer which have proved themselves absolutely intractable to any method of treatment, such as cancers of the liver, cancers of the esophagus, and the upper portion of the stomach, cancers of the lungs, the leukemias, lymphosarcomata, Hodgkins' disease, and malignant tumor of such organs whose very removal would cause death (brain and spinal cord) still have no hope of surviving. Further refinements in destructive methods, such as surgery and radiology, may cut into the mortality of this type of tumor, but the probability that any great advance will be made along these lines is fairly slim.

Our therapy has been limited to the disease when it has been established. The treatment of cancer has been, and no doubt probably will be for some time, that of a destructive

nature. No other method of treatment has been successful in even one proven case. So-called prophylaxis of cancer, such as relief of irritations, the excision of pigmented moles, etc., has not cut our mortality from this disease to any measurable extent. True prophylaxis of cancer must depend upon the finding of the actual cause of the disease. Observations made in our practice prove this. How often do we see a patient in whom cancer in one part of the body has been thoroughly eradicated, later appearing with a cancer in an entirely unrelated site. I recall a patient with a malignancy of the upper lip who was treated and cured, later appearing with a malignancy of the anorectal junction which was treated and cured, and who still later appeared with a malignant prostate, from which he succumbed. Each of you can recall numerous cases of multiple apparently unrelated malignancies.

I believe that cancer patients should not be classified as sufferers from breast cancer, or uterine cancer, but should be recognized as individuals in whom there is a propensity for cancer formation. This idea that cancer is a systemic disease is fast being accepted by those whose work is to any extent the care and treatment of these poor sufferers. In the light of this, even the so-called metastatic transfer of cancer from one breast to the other must be looked on with doubt. Numerous attempts have been made to find the underlying cause. Enormous endowments and foundations have been established, whose sole purpose is the study of causative factors. Theories have been made and discarded, new ones made and discarded, and yet the actual cause of the cancer has not been arrived at. Probably the greatest contribution to our knowledge along this line has been that of Maude Slye in her work with mice. Thirty years of intensive work with her cancer bearing animals, a time which is equivalent to thousands of human years, has definitely shown the hereditary characteristic of this affliction. Some individuals, with no history of any of the so-called predisposing cause of cancer, develop cancer; other individuals in whom the so-called predisposing cause of cancer is working continuously over years, never develop cancer. What is the reason

for a cell changing its characteristic from that of normal tissue to malignant tissue?

Because of the marked differences in development which can be produced by the administration of various hormones, it seems entirely probable that the final solution of this dread question will come out of the biochemist's laboratory. Until then, we must carry on. We must attempt destruction and eradication as early as possible, and in spite of adverse statistics, treat each case with the hope that because of our redoubled efforts this will be another person whom we can greet five years later. The stakes for which we are playing—that of human life itself—are so high that in spite of our depressing mortality, we cannot give up, but must go on and do our best.

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314 *Sweet Bldg.*

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## THE RELATION OF THE SYMPATHETIC NERVOUS SYSTEM TO HEALTH AND LONGEVITY

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During the nineteenth century, medical men, having become germ-conscious, directed their energies to the study and control of the infectious diseases. The century was well spent and the accomplishments of our profession in that work were phenomenal. Most of these diseases are now well under our control and the life expectancy of man has been extended several years by this excellent work. So great has been the change that the tabulations of the causes of death have undergone great changes and the methods of battle against disease have undergone even greater changes. Great, too, have been the changes in the morbid conditions to be combatted by the medical profession, for the infectious diseases of earlier life have been supplanted largely by the organic diseases of later life, and these are the diseases to which we must turn our attention—to determine their causes and establish means of prevention and treatment.

Many of these organic diseases have their origin in the imbalance of the nerves of the vegetative nervous system, and it is my de-

sire to bring to your attention some of these diseases and their relation to this, the first developed nervous system of the body. These diseases are more numerous than we have time to mention so we will try to discuss only a few of the more important ones here.

The diseases of the heart and the blood vessels are so often due to nervous imbalance that we may discuss these profitably. The heart and the arteries are augmented through the sympathetic nerves and are inhibited through the parasympathetic nerves. Observing the case histories of many very old people, ages extending into the nineties and some past the century mark, I became interested in the heart's action, blood pressure and other features of circulation. In all cases of old people observed in which the blood pressure was taken occasionally through the last few years of life, it was noted that the systolic pressure was always normal, or what is usually considered subnormal. They were almost always of the hypotensive type. This caused me to observe more closely the blood pressure in the hypertensive type to try to determine the reasons for the difference in expectancy. My observations were that in this type the patients usually died before they passed beyond the sixties. Again, I noted other differences in the hypertensive expectancy; that those whose pressure crept up gradually might live through many years with the systolic pressure running very high, since the gradual rise permitted the deposit of fibrous tissue in the walls of the arteries to meet the rising resistance; that the wall of the left ventricle became thickened to compensate for the greater requirements of force to drive the blood stream forward; and that in most of my cases of hypertension the patients who had maintained a normal blood pressure through most of life, having developed hypertension suddenly and rapidly before the heart muscle could develop to compensate, died early. Other observations pertained to rupture of the arteries which caused me to seek for more definite reasons for these phenomena.

One of the most important agents having augmentory action on the heart is adrenalin and the more alert surgeons, ever seeking relief through surgical means, have taken advantage of this fact by devising the operation of severing the nerves supplying the adrenal glands to check the excessive secretion



of this hormone. Many patients with hypertension have received much relief by this operation and it may be said to be a surgical success in essential hypertension, but it is not satisfactory in cases due to calcification of the arteries or deposits due to faulty catabolism with diseased kidneys.

Perhaps one of the greatest causes of essential hypertension is the mental state. This is observed in business men whose business activities cause them to live under high nerve tension. This nerve tension of business men seems to have similar action to that of adrenalin and it is directed to the heart and arteries in like manner. It is certainly one of the most important and frequent causes of hypertension and it is one of the most obstinate causes to overcome. Here we may understand well a cause which is too often beyond our ability to correct.

Some of the toxins from focal infections have augmentory action like adrenalin. Barger found that tyramine, a toxin from focal infection, has what he called sympathomimetic action on the heart and arteries, which action is the same as that of adrenalin and chemically tyramine is almost the same as adrenalin. This should bring to our attention the fact that we must eliminate focal infections in seeking the causes of any given case of hypertension though this has been seldom found to be the cause.

While hypertension certainly results from the action of these and like agents operating through the sympathetic nerves, it must be remembered that heredity plays an important part. When we are able to convince parents of this hereditary tendency and have them give their children the early training which may help to overcome it we will have gone far toward the control of this group of morbid conditions. Children with a hereditary tendency for hypertension are usually healthy and active, often study and progress well in school, and have an athletic bent at play. This activity may follow them into business and constitute too great mental activity and strain, resulting in the morbid conditions accompanying hypertension. This often terminates a life of the greatest business activity during the fifties or the sixties. These children are less susceptible to some of the acute infectious diseases, being frequently immune to diphtheria and less susceptible to tuberculosis and

some other infections. The fact that they are seldom sick causes them to be less attentive to the general rules of health. They are the ones who refuse a health examination and are also the ones who die suddenly without the care of a medical man or who disregard medical advice until the morbid conditions have progressed beyond repair.

The treatment of this condition must be directed to the individual needs of each patient. They usually come too late to permit a cure but much may be done to give relief and to prolong life if the patient gives the necessary cooperation. It is not out of place here to mention that some of our most useful drugs in the treatment of other diseases may be dangerous in case of hypertension. Such drugs as adrenalin, ephedrine, benzedrine and camphor are powerful heart stimulants exerting their action through the sympathetic system of nerves which give them very dangerous action in hypertensive diseases. Death has been reported from giving adrenalin during an attack of angina pectoris and the same might result in case of hypertension when the heart is not compensating.

The diseases of the other extreme in blood pressure are not essentially due to the hypotension as the diseases of the hypertensive person are due to hypertension, but the hypotensive type is merely of lower vitality, having less resistance, thus permitting the causes of the diseases to produce their morbid results. In physical exercise they are usually less active and in mental activity they may be less alert, but many of them are persistent in their attempts, often accomplishing more in the end. They are usually more susceptible to the external causes of disease, such as infections, allergens and weather conditions. They are more susceptible to pain and are more often sick, but they are ever mindful of the causes of their sickness and pain and are more careful to avoid such causes. It may be said that they are often complaining but they seldom die from their sickness. It is the rule that these are the ones who live to the most advanced age.

In this type the parasympathetic nerves are in ascendency. Just a little stimulation through these nerves and there is immediate manifestation of disease. Of the agents directing their action through this system of nerves we may mention posterior pituitary extract as



the most active hormone. Most of us have observed the action of this hormone on the uterus and the intestines. It has augmentory action on the body of the uterus and inhibitory action on the os and, when given to one having some foreign body in this organ, its tendency is to contract the body and dilate the os. However, it must be kept ever in mind that the augmentory action precedes and excels the inhibitory action, making it dangerous to attempt to clear the uterus by administering this drug. The contracting action of this hormone is most useful in stopping uterine hemorrhage. We have seen its action in producing peristalsis of the colon while its inhibitory action relaxed the anal sphincter, resulting in fecal discharge. I mention these points because they demonstrate so well the action of this drug and others of its class. So far as I know this hormone does not produce any disease by its excessive action, but it seems possible that some cases of irritation of the bowel may be due to its excessive action.

Again, we observe that certain mental states have augmentory action through this system of nerves. Fear has specific action, causing all of the symptoms which may be produced by anterior pituitary extract. Sudden intense fear causes contraction of the stomach, which is accompanied by loss of appetite. It may be so intense as to cause evacuation of the contents of the bowel and the urinary bladder. Morbid conditions due to other causes may be increased by this mental state, thus exaggerating the symptoms. Those suffering from the allergic diseases are most often made much worse by the fear and dread of the attack and the desired relief may be attained much more readily by allaying the state of fear.

I mentioned above how tyramine, a toxin from focal infections, may act through the sympathetic system to raise the blood pressure. Now let me call your attention to a toxin which directs its action through the parasympathetic system to produce opposite morbid conditions. I have made many experi-

ments with iso-amylamine and find that it seems to direct its action through the parasympathetic system to serve as a cause of several morbid conditions. It may cause arthritis or asthma in the guinea pig and probably may cause the same in man. It is one of the most active toxins in the cause of some diseases. This is another sympathomimetic action mentioned by Barger and this action is similar to that of the allergens. It is through the parasympathetic nerves that the allergens seem to direct their action to the different organs of the body to produce their morbid conditions and, when we shall have solved the perplexing problems of allergens and allergic diseases, it is probable that we shall also have solved many of the changes accomplished in the parasympathetic nerves. In studying the reactions through these nerves it will be observed that the morbid conditions resulting are most often local and that they differ in individuals. In one the reaction may be of the respiratory tract, resulting in hay fever, spasmodic croup, or bronchial asthma; in another it may be of the gastro-intestinal tract, resulting in colicky griping; in another it may be of the urinary tract, resulting in severe cystitis from the contracted bladder; finally it may be of the dermal system, resulting in one of the allergic diseases of the skin. These diseases are most often found in hypotensive persons who are in many cases allergic. It may be further observed that this type of infection is usually of a painful, nagging, chronic nature and seldom fatal. Such patients are inattentive to the advice given them and, if some intercurrent infection does not attack them to prove fatal, they usually live to ripe old age.

The treatment for hypertension is for the prolonging of life of the person, while treatment of hypotension is often for the relief of suffering and the rehabilitation of the patient. We see both types more frequently as the diseases of childhood and early adult life are yielding to our efforts, and we should direct our attention more to these organic diseases to be ready to treat them by the most scientific methods.

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clients' activities were directed solely at the maintenance of the ethics and standards of the profession.

At the headquarters of the Association, officials, including Dr. Olin West, Secretary, and Dr. Morris Fishbein, Editor, said:

The principles and policies of the American Medical Association do not forbid nor have they ever contemplated any opposition to a well considered expanded program of medical service, when the need can be established; neither is there any fundamental principle or policy which in any manner opposes aid to the indigent when indigence can be established.

The American Medical Association has always welcomed investigation by any authorized agency of the nature of its organization or of the conduct of its work or of its activities, firmly reliant in the belief that every action taken by the Association has been in accordance with its constitutional organization in the interests of the public welfare for advancing standards and quality of medical service for the American people; and that at no time has it violated the established law of the federal, state, or municipal governments of this country. Moreover, by the very nature of its organization, it has preserved constantly the democratic principles on which the Government of the United States is founded and maintained.

**A. M. A. INDICTMENT QUASHED!**

Justice James M. Proctor, upholding a defense demurrer to indictments, ruled on July 26 that the American Medical Association and its fellow defendants were not engaged in a trade as defined by the antimonopoly statutes. Counsel for the doctors had contended their activities could not be governed by the Antitrust Law, that they were engaged in a "learned profession" rather than a trade. On December 20, 1938, a District of Columbia Grand Jury, acting on evidence presented by the Justice Department, indicted the American Medical Association, the Medical Society of the District of Columbia, the Washington Academy of Surgery, the Harris County (Texas) Medical Society and twenty-one individual physicians for violation of the Sherman Antitrust Law. These organizations and individuals, the indictment read, were "engaged in a continuing combination in conspiracy in restraint" of trade in hampering the activities of Group Health Association, Inc., for the District of Columbia, an organization established in 1937 to hire physicians and nurses and provide hospital care on a cooperative basis to government employees. Defense attorneys had contended that all their

**NEW STATE HEALTH OFFICER**

Dr. A. B. McCreary of Jacksonville was appointed state health officer to succeed the late Dr. Wilbur A. McPhaul. Governor Cone made the appointment effective August 4. Doctor McCreary has been director of the Bureau of County and District Health Work for the State Board of Health during the past four years. He is a native of Louisville, Ky., and received his doctor of medicine degree from the University of Tennessee at Knoxville.

Doctor McCreary is widely known in public health circles throughout the South, having been actively engaged in this profession for more than fifteen years. Among the positions he has held are: epidemiologist for the Department of Health at Memphis; assistant in public health at the University of Tennessee; director of the Bureau of Epidemiology of the North Carolina State Board of Health; health officer in Northhampton County, Virginia, and Richmond County, North Carolina; and a staff member of the State Hospital at Raleigh, N. C., and St. Joseph's Hospital at Memphis.



## THE FIGHT AGAINST NOSTRUMS AND QUACKERY

Doctors realize there are many harmful and useless nostrums on the market; doctors realize that the sale of these nostrums are a detriment not only to the health of the public but to their own practice. For many years the American Medical Association has been conducting a valiant fight against quackery, often at the hazard of harassing suits for libel. However, the A. M. A. could go no further than to expose falsehoods and advise against the use of unethical products and procedures.

The Federal Trade Commission, which has also for some years been active in its efforts to protect the public along these lines, has been clothed with certain duties under the new food and drug act. This Commission is determined to discharge these duties as fully as possible. Dr. K. E. Miller, Senior Surgeon of the United States Public Health Service, has been detailed to the Federal Trade Commission for the purpose of assisting the Commission in its work of enforcing the limits beyond which the advertiser of a product may not go in representing to the public the merits of a proprietary preparation.

Unfortunately, the Commission does not at the present time have funds with which to fully compensate physicians who are so essential as witnesses when hearings are necessary. However, because of the benefit which will accrue to the public and to the private practice of physicians by the work of the Commission, it is urged that individual doctors and medical societies cooperate as fully as possible with the Commission. Doctor Miller, the Director, has given his assurance that "when hearings are necessary, it is the policy of the Federal Trade Commission to schedule the hearings at or near the place where the headquarters of the respondent are located, so that little or no travel will be involved." He further states: "I am in a position also to assure you that every possible consideration will be given to the conservation of their (the

doctors') valuable time, and to other items to suit their convenience."

Through the cooperation of the Federal Trade Commission and the members of organized medicine, a big step can be taken in the achievement of one of the objectives for which the profession has been striving for many years.

---

## MEDICAL DISTRICT MEETING — A Marianna, July 20

The third annual meeting of the Northwest Medical District was held at Marianna, Thursday afternoon at 2:30 o'clock, July 20, with headquarters at the Community House. There was a total registration of 93, of which number, 54 were Association members (from this district, 48); and 39 were visitors. The names of the lady guests have been omitted from the list following this write-up as very few of them registered; they assembled at the Chipola Hotel to participate in the afternoon's entertainment and did not go to the Community House to register.

Dr. Carol C. Webb of Pensacola, senior councilor, called the general session to order promptly at 2:30 p. m. Dr. N. A. Baltzell of Marianna welcomed the members and guests in a very cordial manner. Dr. Leigh F. Robinson, president of the State Association, then outlined the activities of the Association and brought to the audience many interesting facts concerning the work of the various committees, councilors and officers. It was quite evident from Doctor Robinson's address that he, as the new president of the State Association, is taking his leadership seriously and has been exceptionally active in many phases of the Association's work.

Dr. Shaler Richardson of Jacksonville, secretary-treasurer and editor of the Journal, then reviewed the Association's activities as carried on through the home office and the Florida Medical Journal. He commented on the growth of the Association and the vast increase in the activities of the various com-

mittees, the central office and the officers of the Association. The circulation of the Journal has increased until it is now necessary to purchase 1,600 copies each month, to meet the demand. The total membership of the Association is the highest on record, there being now a total of 1,321 members in good standing, on the roll.

Dr. Herman Watson, chairman of the Council, was unable to be present. Dr. J. Sam Turberville of Century, president-elect, was recognized by the chair and made a brief address. Dr. Gilbert S. Osincup of Orlando, chairman of the Executive Committee, presided during an open discussion of the understanding between the physicians of certain counties, the Florida Medical Association and the Farm Security Administration. A large number of the doctors present took part in this discussion. Doctor Osincup, in expressing his appreciation, stated that the experiences related by the various doctors at this meeting would enable him to talk more intelligently at his next conference with the officers of the Farm Security Administration.

Dr. T. Z. Cason of Jacksonville, chairman of the Association's Committee on Medical Postgraduate Course, was recognized. Doctor Cason took this opportunity to review the short courses for the past seven years and, by the use of a conventional map, he exhibited a comparison of the number of licensed practitioners in each county to the total registration from each county, during the past seven years. A questionnaire was distributed and each doctor present was requested to answer the questions indicated, as a guide to the Committee in formulating future plans. Dr. Herbert L. Bryans of Pensacola, one of the Association's delegates to the House of Delegates of the American Medical Association, was called upon. Doctor Bryans read a brief report and stated that the complete report, which had been read before the Executive Committee, was being published in the July Florida Medical Journal.

Dr. A. E. Conter of Apalachicola was recognized by the Chair. Doctor Conter presented an unusual case history, with the request that any physician who had observed a similar case contact him at the close of the session. Four of the five past presidents in this district were present at the meeting and were recognized

in turn by Doctor Webb: Dr. Henry E. Palmer, Tallahassee; Dr. F. Clifton Moor, Tallahassee; Dr. J. C. Davis, Quincy; and Dr. Herbert L. Bryans, Pensacola. Dr. J. H. Pierpont of Pensacola, the oldest past president, having served his first term in 1890, was unable to be present. Dr. W. Henry Spiers of Orlando, the immediate past president of the Association, was present and was recognized by the Chair.

The next order of business was the selection of a meeting place for 1940. Doctor Bryans, speaking for the Escambia County Medical Society, invited next year's meeting to Pensacola. Dr. W. C. Roberts of Panama City, on behalf of the Bay County Medical Society, invited the meeting to Panama City. A vote was taken, with the result that Pensacola was selected as the 1940 meeting place. Dr. R. N. Joyner of Marianna, chairman of the local committee on arrangements, made a number of announcements concerning the entertainment and the dinner to be held at the Chipola Hotel.

The gavel was turned over to Dr. B. A. Wilkinson of Tallahassee, junior councilor, who presided during the scientific session. Four very interesting and instructive papers were presented by the following essayists: Dr. Sidney G. Kennedy and Dr. J. H. Pierpont of Pensacola on "Hemorrhage Complicating Empyema Thoracis"; Dr. Nathan S. Rubin of Pensacola on "The Cross-Eyed Child"; Dr. Joe I. Turberville of Century on "Fractures of the Pelvis"; and Dr. J. M. Hoffman of Pensacola on "Back Pain." After the reading of each paper, Doctor Wilkinson called for discussions and the scientific session proved to be a very valuable part of this district meeting.

Immediately following the scientific session, the doctors, ladies and guests were invited to a cocktail party in the recreation room of the Community House. At 7 p. m. dinner was served at the Chipola Hotel. Dr. R. N. Joyner of Marianna presided and presented officers of the Association and distinguished guests, with a flow of oratory that held the close attention of everyone present. Following the dinner, Dr. C. H. Ryals of Grand Ridge, the speaker of the evening, took as his subject, "Some Experiences of a Country Doctor."





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Dr. Herbert L. Bryans then delighted the audience by showing moving pictures he had taken at last year's annual meeting, held at Panama City. As the reel was run, Doctor Bryans commented on the various familiar faces that appeared. A great many of the doctors and guests present at this meeting saw themselves in moving pictures for the first time.

The tables were arranged fan-shaped in the large dining room, beautifully decorated with flowers. An exceptionally fine orchestra interspersed the program with delightful music. Seventy-four persons were served during the dinner.

Some twenty or thirty ladies met at the Chipola Club and enjoyed the afternoon at bridge. Mrs. B. M. Rhodes of Tallahassee made high score. The trip through the Florida Caverns Park was cancelled because of rain.

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*Marianna:* N. A. Baltzell, R. N. Joyner, C. W. McDonald, D. A. McKinnon, W. R. Wandeck, C. D. Whitaker. *Orlando:* G. S. Osincup. *W. H. Spiers. Panama City:* J. M. Nixon, Herman Perkins, W. C. Roberts. *Pensacola:* H. L. Bryans, G. N. Click, J. P. Daniels, J. H. Fellows, L. C. Fisher, C. J. Heinberg, W. P. Hixon, J. M. Hoffman, S. G. Kennedy, N. S. Rubin, A. L. Stebbins, A. W. White.

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*Visitors—Malone:* R. L. Kennedy. *Marianna:* H. B. Smith. *Dothan, Ala.:* John T. Ellis, W. P. Roberts. *Augusta, Ga.:* W. C. Salley. *Donalsonville, Ga.:* H. B. Jenkins. *Thomasville, Ga.:* Rudolph Bell.

#### MEDICAL DISTRICT MEETINGS 1939

**We're Going—  
Are You?**

Marianna (A) . . . .	July 20
Palatka (C) . . . .	Sept. 14
Lakeland (D) . . . .	Sept. 28
West Palm Beach (F) . . . .	Oct. 12
Ocala (B) . . . . .	Oct. 26
Sanford (E) . . . . .	Nov. 9

#### BIRTHS, MARRIAGES, AND DEATHS

##### BIRTHS

Dr. and Mrs. H. B. Goodwin, Jr., of Fort Pierce announce the birth of a son on June 27.

Dr. and Mrs. Paul L. White of St. Petersburg announce the birth of a son, Paul Leslie, Jr., on July 11 at the Tampa Municipal Hospital.

##### MARRIAGES

Dr. R. L. Laymon of Miami and Miss Marjorie Rich were married in Washington, D. C., on July 7.

Dr. E. H. Adkins of Miami Beach and Mrs. Mildred K. Clark, formerly of Boston, were married June 30 at Miami Beach.

Dr. R. Spencer Howell of Miami and Miss Mary Louise Mullino of Montezuma, Georgia, were married on June 7 in Montezuma.

##### DEATHS

Dr. Wilbur A. McPhaul, Jacksonville, State Health Officer, died August 1, following an illness of several months.

Dr. John T. Denton of Sanford died in a Greenville, N. C., hospital on August 3, after a sudden illness at Saluda, where he was attending the Southern Pediatric Seminar.

Dr. Gaston Day of Jacksonville died suddenly at his home on August 5.

#### STATE NEWS ITEMS

Dr. Julius R. Pearson of Miami left recently for Chicago, New York and New Haven, Connecticut, where he expects to take some special work and visit clinics. Doctor and Mrs. Pearson will spend two months traveling through the United States, visiting the World's Fairs in San Francisco and New York.

\* \* \*

Dr. L. C. Gonzalez of Jacksonville will spend the ensuing year at Johns Hopkins University, taking a postgraduate course in venereal disease control.

\* \* \*

Dr. B. B. Sory, Jr., of Palm Beach is vacationing in Paris, France, prior to taking advanced medical study in Vienna, Austria.

\* \* \*

Dr. Maurice E. Heck of Miami took special work in surgery and gynecology at Chicago and Mayo clinics during the month of August.



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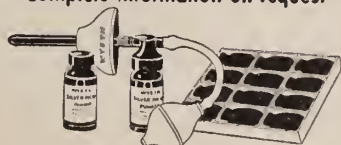
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Dr. Fred D. Bartleson of Ft. Myers was recently appointed medical examiner in his area, for the Civil Air Authorities.

\* \* \*

Dr. M. A. Lischkoff of Pensacola is spending the month of August in the East, attending the Jackson Course in Broncho-esophagoscopia in Philadelphia.

\* \* \*

Dr. H. V. Weems of Sebring was principal speaker at the meeting of the local Rotary Club on July 24. His subject was "The Progress of Medical Science."

\* \* \*

Dr. C. Larimore Perry of Miami left recently for an extended vacation, during which time he will attend clinics in New York, Baltimore and Boston and spend some time in the White Mountains of New Hampshire.

\* \* \*

The next written examination of the American Board of Obstetrics and Gynecology for Group B candidates will be held in various cities of the United States on Saturday, January 6, 1940, at 2 p. m. Applications for admission to Group B, Part I, examinations must be on file in the secretary's office not later than October 4, 1939.

The general oral and pathological examinations (Part II) for all candidates in Groups A and B will be conducted by the entire Board in Atlantic City, N. J., on June 8, 9, 10, and 11, 1940. Applications for admission to Group A, Part II examinations must be on file in the secretary's office not later than March 15, 1940. For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh, Pa.

\* \* \*

The following Florida doctors read papers at the last A. M. A. meeting, held in St. Louis, Mo.: George D. Lilly, Miami, "Complications of Appendical Peritonitis," Section on Surgery, General and Abdominal; Warren W. Quillian, Coral Gables, "Respiratory Infections: Types and Clinical Course as Observed in Florida Pediatric Practice," Section on Pediatrics; H. Marshall Taylor, Jacksonville, "Otitis and Sinusitis in the Swimmer," (Chairman's address) Section on Laryngology, Otology and Rhinology.

The thirty-ninth annual meeting of the Chattahoochee Valley Medical Association was held at Radium Springs, near Albany, Georgia, July 11, 12, and 13. Dr. J. Sam Turberville of Century, president, presided during this meeting. Dr. M. Y. Dabney of Birmingham was elected president and Dr. Frank K. Boland of Atlanta was re-elected secretary of the organization for the ensuing year.

## COMPONENT COUNTY SOCIETIES

### BREVARD COUNTY MEDICAL SOCIETY

The regular meeting of the Brevard County Medical Society was held on the evening of July 19 at the office of Dr. T. C. Kenaston of Cocoa. Moving pictures of tuberculosis therapy were shown. It was decided to hold the next meeting at Melbourne on the evening of August 9.

\* \* \*

### DADE COUNTY MEDICAL SOCIETY

The August meeting of the Dade County Medical Society was held at the Ingraham Building on the evening of the 1st. The program consisted of two papers: "Common Foot Ailments" by E. W. Cullipher, and "Endocrinology of Menstruation" by L. W. Dowlen.

\* \* \*

### ESCAMBIA COUNTY MEDICAL SOCIETY

The Escambia County Medical Society is sponsoring a health section in the Pensacola News-Journal. A committee from the society is to pass on news matter and advertisements which are to appear in the section. In the Pensacola Journal of July 23 a notice was published to this effect, naming all of the officers and members of the Escambia County Medical Society.

On July 24 the Pensacola News ran a long article under the caption, "Horse and Buggy Doctor Faced Many Handicaps." This article gave a brief history of the society and declared that the Pensacola Medical Society was the first organization of its kind in the history of West Florida. It was stated that 13 doctors rented a club room and fitted it up as the home of the society, holding bi-monthly meetings. The only living member of that group is Dr. J. H. Pierpont who recalls that he and his colleagues found those meetings and exchange of ideas of enormous benefit. Doctor Pierpont is the oldest past



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president of the Florida Medical Association. The article further states that the Pensacola Medical Society became the Escambia County Medical Society in 1892 when it became a unit of the Florida Medical Association.

\* \* \*

#### PALM BEACH COUNTY MEDICAL SOCIETY

Dr. Michael Smith of West Palm Beach was the principal speaker at the meeting of the Palm Beach County Medical Society held on the evening of July 24. The subject presented was "The Modern Conception of Tuberculosis." This was followed by a sound film on tuberculosis, which had been furnished by the Florida Tuberculosis and Health Association.

\* \* \*

#### PINELLAS COUNTY MEDICAL SOCIETY

Dr. W. O. Fowler of the State Tuberculosis Sanatorium was principal speaker at the meeting of the Pinellas County Medical Society on the evening of July 7, taking the place of Dr. R. D. Thompson, scheduled speaker, who was unable to be present. Doctor Fowler discussed "Case Findings in Tuberculosis and Modern Trends in Therapy."

Three constructive papers were read at the Academy program of the society on July 21: "Appendicitis," by L. M. Gable; "High Blood Pressure," by J. A. Bradley; and "Diseases of Sigmoid and Rectum," by C. E. Hebard.

\* \* \*

#### PUTNAM COUNTY MEDICAL SOCIETY

The regular meeting of the Putnam County Medical Society was held Tuesday evening, July 11, at 7 o'clock at the Marian Hotel, Palatka. Honor guest and speaker of the evening was Stewart G. Thompson, managing director of the Florida Medical Association.

A committee was appointed, composed of Drs. A. P. Gurganious, chairman, Z. Brantley, and F. Emory Bell, to make arrangements for the Annual Medical District Meeting to be held in Palatka on September 14. The society is busily planning and looking forward with much pleasure to this meeting.

Dr. E. W. Ford, Crescent City, president, on behalf of the society, presented Dr. A. P. Gurganious, whose recent marriage was an event of interest, with a bouquet for his bride.

### ABSTRACT DEPARTMENT

*Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.*

**A Light Hyperextension Back Brace, JEWETT, EUGENE L., Orlando, J. Bone & Joint Surg. 19: 1128-1129 (Oct.), 1937.**

The author describes a light hyperextension back brace modeled after that perfected by Griswold in 1936. Its main advantage is its lightness (the brace complete weighing only 2½ pounds) which is a very important item to the ambulatory patient who must wear some form of hyperextension mechanism for months.

Three illustrations of this brace are to be found in the published article.

**The Climatic Treatment of Hay Fever and Asthma, with Special Reference to Florida, METZGER, FRANK C., Tampa, J. A. M. A. 112: 29-32 (Jan. 7), 1939.**

The author makes an earnest plea that allergic patients be spared the economic and psychic upheaval incident to change of climate, advised by their physician without adequate knowledge of their individual sensitizations.

Those obtaining partial or complete relief after moving to Florida constitute too small a percentage of the whole to in any way justify their removal from their native habitat and when relief is obtained a careful history will often show that "some causative factor has been discovered and eliminated that could as easily have been removed at home."

The fact is stressed that before removal to a different locality is advised there must be a definite knowledge of the allergen which precipitates the patient's trouble and in what locality it is absent or least prevalent.

The author divides hay fever into two classes: pollinosis, that due to pollens; and allergic rhinitis, that due to other allergens. In Florida the former constitute 24 per cent and the latter 76 per cent, practically reversing the ratio of the northern states. The reason apparently is that pollen concentrations are not nearly so great as in the northern, eastern and midwestern states, and "with the exception of patients sensitized to oak or highly sensitized





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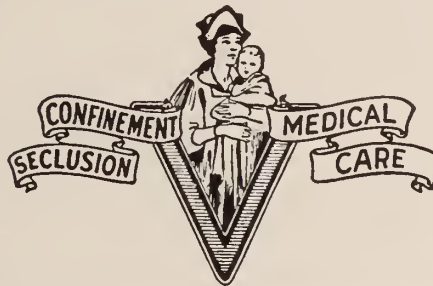
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to grass pollens, persons with pollinosis should do well in the state."

On the other hand, asthmatics sensitive to house dust should not take up residence here, as specimens of house dust were reported to contain greater concentrations of the "unknown offending allergens" than elsewhere.

There is apparently a dearth of allergic rhinitis due to animal inhalants here and occupational dust is a very infrequent cause. Food sensitivity, particularly to citrus fruits, condiments and sea food seem to be definite factors in the allergic rhinitis complex.

*Editor's Note—The author will have performed a great service to this State, the physicians of the State and the individual patients if through his efforts there can be a reduction in the number of disappointed and embittered patients who come here for relief only to find themselves worse.*

## BOOKS RECEIVED

*Acknowledgment of books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review, as expedient.*

CANCER OF THE BREAST AND CANCER OF THE UTERUS. (Second Edition). By MARION ELLSWORTH ANDERSON, A.B., M.D. This small book, dedicated to "The Nurses," is designed "for the family physician or the man in general practice. It may be of some value to the registered nurse." The greater part of profits from the sale of this brochure to go to the Sims-Cullen Cancer Fund. Paper. Price, \$1.00. Pp. 106, profusely illustrated. Clinton, Iowa: The Franklin Press.

WHAT IT MEANS TO BE A DOCTOR. By DWIGHT ANDERSON. This volume is a brief treatise, aiming to convey an impression of the doctor's way of life; his character, his education, his ability, and his skill. A questionnaire which asked four questions was sent to 500 general practitioners, surgeons, pediatricians, and many other specialists throughout the country. The questions: 1. What qualities of mind and character do you consider most important for the practice of medicine as a profession? 2. How old were you (approximately) when you determined to be a doctor? 3. What decided you? 4. If you had a son, would you wish him to select medicine as a career? The replies are digested. Cloth. Price, \$1.00; paper, 25 cents. Pp. 96. Public Relations Bureau, Medical Society of the State of New York, 2 East 103rd Street, New York City, 1939.

THE OPHTHALMOSCOPE AND STUDIES OF THE FUNDUS OCULI IN IMPORTANT PATHOLOGICAL CONDITIONS. By American Optical Co. This booklet presents a series of fundus oculi studies, showing pathological changes from normal which are frequently encountered by ophthalmologists in their diagnostic work. Paper. Pp. 32, illustrated by an anatomical artist under direct supervision of an ophthalmologist. Copy will be sent on request. American Optical Co., Southbridge, Mass.

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## COMPONENT SOCIETIES BY DISTRICTS — FLORIDA MEDICAL ASSOCIATION

Dis- tricts	COUNTY SOCIETIES	PRESIDENT	SECRETARY	MEETING DATE	COUNCILOR and Counties Not In- cluded in First Column	Members	
						Total	Paid
Northwest District (A) Mariana July 20, 1939	Bay	Donald S. Fraser, M.D. Panama City	William C. Roberts, M.D. Panama City		A-1-'40 Carol C. Webb, M.D. Pensacola	12	100%
	Escambia	L. C. Fisher, Jr., M.D. 816 N. Palafox St. Pensacola	J. M. Hoffman, M.D. 1221 E. Desoto St. Pensacola	2nd Tuesday 8:00 P. M.		44	38
	Walton-Okaloosa	A. G. Williams, M.D. Lakewood	R. B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P. M.		6	100%
	Washington-Holmes	W. D. Ramsey, M.D. Noma	L. H. Paul, M.D. Bonifay		Santa Rosa	8	7
	Franklin-Gulf	Chapman Dykes, M.D. Carrabelle	A. L. Ward, M.D. Port St. Joe	3rd Thursday	A-2-'41 B. A. Wilkinson, M.D. Tallahassee	6	100%
	Jackson	C. J. Price, M.D. Alford	R. N. Joyner, M.D. Marianna	2nd Tuesday 7:30 P. M.		13	12
	Leon-Gadsden-Liberty- Wakulla-Jefferson	W. W. Massey, M.D. 204 N. Madison St. Quincy	B. A. Wilkinson, M.D. Telephone Bldg. Tallahassee	Quarterly 3:00 P. M.	Calhoun	38	33
North Central District (B) Ocala October 26, 1939	Columbia	W. M. Ives, M.D. 132 N. Marion St. Lake City	Harry S. Howell, M.D. Blanche Hotel Annex Lake City	1st Monday 7:30 P. M.	B-3-'41 W. S. Nichols, M.D. Lake City	21	16
	Madison	E. Long, M.D. Madison	A. F. Harrison, M.D. Madison			3	2
	Taylor	Geo. H. Warren, M.D. Perry	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P. M.	Baker-Dixie-Hamilton- Lafayette-Suwannee	8	6
	Alachua	J. E. Malnes, Jr., M.D. 433 E. Main St. N. Gainesville	J. Maxey Dell, Jr., M.D. 333 W. Main St., S. Gainesville	2nd Friday 7:30 P. M.	B-4-'40 James L. Strange, M.D. McIntosh	29	24
	Marion	Carl S. Lytle, M.D. Dunnellon	R. C. Cumming, M.D. Commercial Bank Bldg. Ocala	3rd Thursday 12:30 P. M.		23	100%
	Pasco-Hernando- Citrus	Claude L. Carter, M.D. Inverness	G. R. Creekmore, M.D. Brooksville	2nd Thursday 7:00 P. M.		15	100%
	Sumter	Clyde L. Carter, M.D. Wildwood		2nd Tuesday	Bradford-Gilchrist- Levy-Union	3	2
N. E. District (C) Palatka September 14, 1939	Duval	Thomas E. Buckman, M.D. 1022 Park St. Jacksonville	Lauren M. Sompayrac, M.D. 459 St. James Bldg. Jacksonville	1st Tuesday 8:15 P. M.	C-5-'41 R. B. McIver, M.D. Jacksonville	174	172
	St. Johns	R. D. Harris, M.D. St. Augustine	G. Walter Potter, M.D. East Coast Hospital St. Augustine	3rd Tuesday 8:30 P. M.		10	100%
	Putnam	Edward W. Ford, M.D. Crescent City	C. M. Knight, M.D. Palatka	2nd Tuesday in Feb., April, June, Aug., Oct., Dec. 7:00 P. M.	Clay-Nassau C-6-'40 George M. Green, M.D. Daytona Beach	11	10
	Volusia	Maximilian Stern, M.D. Box 5098 Daytona Beach	R. L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P. M.	Flagler	41	40
Southwest District (D) Lakeland September 28, 1939	Hillsborough	J. W. Alsbrook, M.D. 120 N. Collins St. Plant City	James S. Grable, M. D. 811 Citizens Bank Bldg. Tampa	1st Tuesday 8:00 P. M.	D-7-'41 W. C. McConnell, M.D. St. Petersburg	110	94
	Manatee	S. G. Hollingsworth, M.D. 451 12th St. Bradenton	M. M. Harrison, M.D. Professional Bldg. Bradenton	3rd Tuesday 7:00 P. M.		14	100%
	Pinellas	E. C. MacCordy, M.D. 366 First Federal Bldg. St. Petersburg	W. C. McConnell, M.D. 1001 First Federal Bldg. St. Petersburg	1st and 3rd Fridays 6:30 P. M.		93	100%
	Sarasota	T. W. Taylor, M.D. Professional Bldg. Sarasota	Stanley T. Martin, M.D. Sarasota	2nd Tuesday 8:30 P. M.		17	14
	DeSoto-Hardee-High- lands-Charlotte- Glades	Ben D. Spears, M.D. Wauchula	Howard V. Weems, M.D. 22 Oak St. Sebring	2nd Tuesday 8:00 P. M.	D-8-40 Herman Watson, M.D. Lakeland	20	100%
	Lee	C. Gordon Merrick, M.D. 26 Leon Bldg. Fort Myers	H. L. Allan, M.D. 312 Pythian Bldg. Fort Myers	3rd Friday 7:30 P. M.		14	12
	Polk	John F. Wilson, Jr., M.D. Box 254 Lakeland	J. R. Boulware, Jr., M.D. P. O. Box 367 Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P. M.	Collier-Hendry	62	100%
South Central District (E) Sanford November 9, 1939	Brevard	W. J. Creel, M.D. Eau Gallie	I. K. Hicks, M.D. Melbourne	3rd Tuesday	E-9-'40 W. C. Page, M.D. Cocoa	11	8
	Lake	W. G. DeVane, M.D. Groveland	Oliver Emerson, M.D. Tavares	1st Thursday 12:30 P. M.		18	13
	Orange	C. D. Hoffmann, M.D. 120 E. Robinson St. Orlando	Fred Mathers, M.D. Box 53 Orlando	3rd Wednesday 8:30 P. M.		77	75
	Seminole	Thomas F. McDaniel, M.D. Seminole County Bank Bldg. Sanford	Douglas G. Scott, M.D. 212 N. Park Ave. Sanford	2nd Monday 7:00 P. M.	Osceola	12	100%
	St. Lucie-Okeechobee Indian River-Martin	J. D. Parker, M.D. Box 942 Stuart	Adrian M. Sample, M.D. Ft. Pierce	3rd Thursday 8:00 P. M.	E-10-'41 A. M. Sample, M.D. Ft. Pierce	17	100%
	Broward	R. L. Ellison, M.D. 814 Sweet Bldg. Ft. Lauderdale	Oliver C. Brown, M.D. 915 Sweet Bldg. Fort Lauderdale	4th Wednesday 8:00 P. M.	F-11-'40 Lloyd J. Netto, M.D. West Palm Beach	34	100%
S. E. District (F) West Palm Beach October 12, 1939	Palm Beach	Gaylord Lewis, M.D. 916 Harvey Bldg. W. Palm Beach	C. Jennings Derrleck, M.D. Box 574 W. Palm Beach	4th Monday 8:00 P. M.		58	100%
	Dade	M. Jay Filpse, M.D. 305 Huntington Bldg. Miami	Franz Stewart, M.D. 1105 Huntington Bldg. Miami	1st Tuesday 8:30 P. M.	F-12-'41 Kenneth Pbillips, M.D. Miami	295	263
	Monroe	Harry C. Galey, M.D. 532 Fleming St. Key West	W. R. Warren, M.D. 511 Eaton St. Key West	1st Sunday 9:00 P. M.		4	100%



STATE AND SECTIONAL MEETINGS

SOCIETY	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association.....	Leigh F. Robinson, Ft. Lauderdale	Shaler Richardson, Jacksonville...	Tampa, 1940
Florida Medical Districts:			
A—Northwest .....	Carol C. Webb, Pensacola.....	Stewart Thompson, Jacksonville...	Marianna, July 20, 1939
B—North Central .....	J. L. Strange, McIntosh.....	" " "	Ocala, Oct. 26, 1939
C—Northeast .....	George M. Green, Daytona Beach.	" " "	Palatka, Sept. 14, 1939
D—Southwest .....	Herman Watson, Lakeland.....	" " "	Lakeland, Sept. 28, 1939
E—South Central .....	W. C. Page, Cocoa.....	" " "	Sanford, Nov. 9, 1939
F—Southeast .....	Lloyd J. Netto, West Palm Beach.	" " "	West Palm Beach, Oct. 12, 1939
Alabama Medical Association.....	M. S. Davie, Dothan.....	D. L. Cannon, Montgomery.....	Birmingham, April 16-18, 1940
Georgia, Medical Assn. of.....	W. H. Myers, Savannah.....	E. D. Shanks, Atlanta.....	Savannah, April 23-26, 1940
Florida—			
State Dental Association.....	R. P. Taylor, Jacksonville.....	E. C. Lunsford, Miami.....	West Palm Beach, Oct. 12-14, 1939
Soc. of Derm. and Syph.....	Elmo D. French, Miami.....	Lauren M. Sompayrac, Jacksonville	Jacksonville, Nov. 1939
East Coast Medical Association.	Frederick J. Waas, Jacksonville ..	A. J. Logie, Jacksonville.....	Jacksonville, Nov. 10-11, 1939
State Hospital Association.....	J. H. Therrell, Chattahoochee....	Mr. Fred M. Walker, Jacksonville..	Mississippi, March, 1940
Assn. of Industrial Surgeons.....	C. E. Tumlin, Miami.....	A. M. Bidwell, Tampa.....	Tampa, 1940
Internists' Society.....	Norval M. Marr, St. Petersburg....	Kenneth Phillips, Miami.....	Tampa, 1940
Medical Postgraduate Course....	Turner Z. Cason, Jacksonville....	Chairman	Jacksonville, 1940
Soc. of Ophthal. & Otol.....	S. B. Forbes, Tampa.....	Temporary Chairman.....	Tampa, 1940
State Nurses Association.....	Mrs. Inez Nelson, Orlando.....	Mrs. Phyllis Leonard, St. Augustine	Lakeland, Nov. 6-8, 1939
Pediatric Society .....	Warren W. Quillian, Coral Gables ..	G. N. Leonard, Miami Beach.....	Tampa, 1940
Pharmaceutical Association.....	Mr. S. F. Harris, Jacksonville.....	Mr. A. W. Morrison, Miami.....	Tampa, May, 1940
Public Health Association.....	Mr. S. D. Macready, W. P. Beach ..	E. M. L'Engle, Jacksonville.....	Jacksonville, 1939
Radiological Society.....	H. B. McEuen, Jacksonville.....	J. N. Moore, Ocala.....	Tampa, 1940
Railway Surgeons' Association....	H. D. Clark, Ft. Pierce.....	W. C. Page, Cocoa.....	Tampa, 1940
Tuberculosis & Health Assn.....	Mr. G. E. Therry, W. Palm Beach ..	Mrs. May Pynchon, Jacksonville....	Spring, 1940
Chattahoochee Valley Med. Assn..	M. Y. Dabney, Birmingham.....	Frank K. Boland, Atlanta.....	Albany, Ga., July 9-11, 1940
Gulf Coast Clinical Society.....	J. H. Dodson, Mobile.....	C. C. Rouse, Mobile.....	Mobile, Oct. 26-27, 1939
Internat. Assn. Milk Sanitarians..	Mr. V. M. Ehlers, Austin, Texas....	Mr. C. Sidney Leete, Albany, N. Y..	Jacksonville, Oct. 25-27, 1939
Southeastern Derm. Assn.....	J. R. Allison, Columbia.....	Howard King, Nashville.....	Nashville, Sept. 3, 1939
Southeastern Surgical Congress....	R. L. Sanders, Memphis.....	B. T. Beasley, Atlanta.....	Birmingham, Mar. 11-13, 1940
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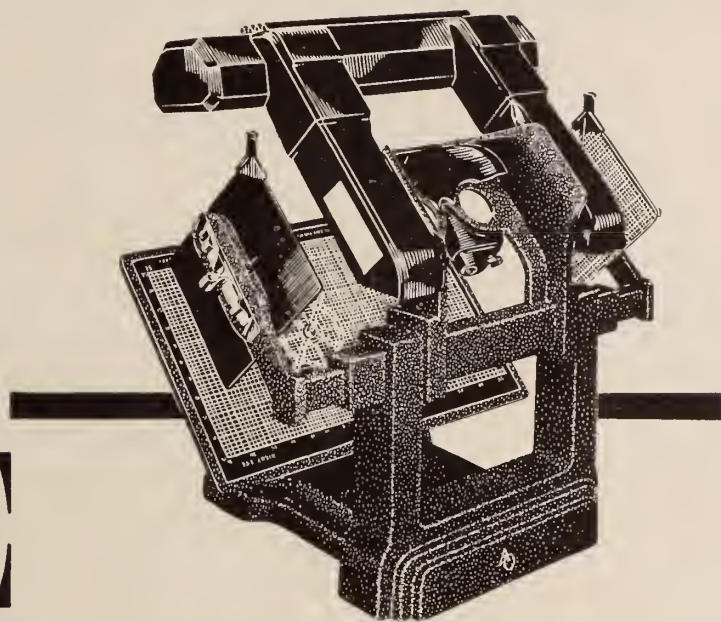
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## SOME OBSERVATIONS ON THE TREATMENT OF PELLAGRA

J. FRANK WILSON, M.D.

Jacksonville

Until the notable work done by Goldberger and Wheeler in Mississippi and Georgia in 1925, we were completely in the dark as to the etiology of pellagra. They were the first to prove definitely that it was of dietary origin. Before that time and for several years afterward there was a great deal of controversy as to whether the disease was of dietary or infectious origin. There seemed to be some grounds for the belief that it was contagious, or at least infectious, for it apparently occurred in epidemic form, whole families being affected and then later other families contracting the disease upon moving into the same house. We have come to see that the new families lived in the same circumstances as the former ones and probably on the same diets. That there was some cause associated with food had been suspected for many years, but most theories attempted to blame some certain food or contamination, instead of a something lacking in the food. There was one theory that the cause was corn which had become spoiled in some manner and had grown a fungus.

Goldberger and Wheeler had a large number of patients upon whom to work. They spent long periods of time working in the insane asylums where whole buildings, at that time, were devoted to the care and treatment of pellagrins. Some of the patients were kept upon the diet on which they had developed the disease. Other groups had additions of various foods; they gave brewer's yeast to some, liver to others, and to others just a diet rich in proteins, beef, milk, eggs, etc. The patients who were kept on the old diets rapidly declined and died, for these were far advanced cases with mental symptoms sufficient to have them committed to institutions. Those with additions to their diets improved if the proper

foods had been added. The conclusion was reached that there was a pellagra preventative factor in several foods of high protein value, the richest sources being brewer's yeast and liver. They simply called this factor pp, stating that it was either a new vitamin which might be named G, or that it was a fraction of vitamin B. The latter has proved to be the case.

Vitamin B is of a very complex nature, not all of its fractions being thoroughly understood. There are the so-called absorbate products, thiamin, or B<sub>1</sub>; riboflavin, or B<sub>2</sub>; and a filtrate from which recently nicotinic acid has been isolated. Other filtrate factors are more or less vague in their relation to the human body. There is one which is associated with dermatitis in chicks but it has not been established that this is the factor concerned in the dermatitis of pellagra.

Elvehjem<sup>1</sup> discovered that nicotinic acid was a cure for blacktongue in dogs and, as it is thought to be analogous to pellagra in man, he suggested that it be tried clinically. After Spies<sup>2</sup> and others tried it with spectacular results, it has come to be the accepted treatment in a very short time. When this substance is given, the mucous membrane and gastro-intestinal lesions clear up with remarkable rapidity, usually in about forty-eight hours. The sore mouth heals, the diarrhea stops, and there is a general feeling of well-being but when used alone it has little or no effect on the polyneuritis, which is almost always a distressing symptom. It also has very little effect on the dermatitis if it is severe with fissures and secondary infection.

It seems to have been proved clinically by Vilter and Spies<sup>3</sup> that it is necessary to increase the dose of nicotinic acid from time to time in order to maintain a steady improvement. After the patient reaches a certain stage he more or less comes to a standstill or even retrogresses on amounts which were adequate in the beginning. If, instead of increasing the dose, thiamin is given, the same result is noted but after a month or two there is a relapse and it is necessary either to increase the dosage or to add another fraction at this stage.

Read before the Sixty-sixth Annual Meeting of the Florida Medical Association, held at Daytona Beach, May 1, 2 and 3, 1939.

If riboflavin is added, immediate improvement is again noted. It is not understood whether riboflavin acts directly on the pellagra or enhances the action of the nicotinic acid and thiamin. In view of these facts, it is reasonable to suppose that the remainder of the vitamin is necessary to perfect health, as each fraction seems to be more potent when accompanied by another.

It seems to me the logical method of treating pellagra would be to supply the entire vitamin B complex in a preparation which is obtained from natural sources and, in addition, to give the specific fractions which are obviously lacking, nicotinic acid for the gastrointestinal symptoms and thiamin for the neurological symptoms. As one fraction seems to supplement the other, smaller doses would be required to get beneficial results; also the patient will receive the other factors in the complex which, although their function is not known, may aid directly in his recovery or may make the known fractions more potent.

The reason that I say the vitamin B complex should be obtained from natural sources is that, in the first place, that obtained from liver and yeast seems to be the most effective and it has been demonstrated that synthetic vitamins have entirely different reactions from the natural ones, differing from each other radically in accordance with the source from which they are obtained. For instance, there are now ten different forms of vitamin D, some of which are much more toxic than others. In the second place, the complete complex should be given so as to obtain the balance of the filtrate, the chemistry of part of which is unknown.

The diet may not be wholly at fault; the preparation of food is almost as important as the food itself. Part of vitamin B, thiamin and riboflavin, is destroyed by excessive heat and all of the vitamin is soluble and may be drained off in the juices before serving. Nicotinic acid though soluble in hot solutions may remain solid in table form and pass through the intestinal tract unabsorbed if the mucosa is atrophied and hydrochloric acid is lacking from the gastric juice. It is desirable to dissolve the nicotinic acid before giving it and in extreme cases it should be given by hypodermic.

The ordinary dose of nicotinic acid is 100 to 150 mg. a day, usually 50 mg. after each

meal. This often gives a transient reaction but this is harmless, aside from a few minutes' discomfort, and is no indication for reduction in the size of the dose. Sebrell and Butler,<sup>4</sup> Spies, and others have shown that very much larger doses may be given without serious results and that the reactions do not occur with any regularity and may cease altogether. The hypodermic dose is usually about 10 mg. but may be increased.

Pellagrins present a social problem for, as a rule, the disease recurs year after year and it is difficult if not impossible to change their mode of living. I have found it to be a waste of time to prescribe a diet unless they are hospitalized or put in someone's care. Their economic condition is such that they cannot obtain the proper food and their mental processes are so slowed either from heredity or from the effects of the pellagra that they cannot properly prepare it. In fact most of them seem to prefer a pellagra-producing diet.

When first seen these patients have usually been taking brewer's yeast, for when pellagra is suspected either in the clinics or by the public health nurses the yeast is immediately prescribed. The State Board of Health for a time furnished free yeast to indigent patients and for that reason we see very seldom well developed pellagra cases. The yeast is so unpalatable and the dose is so large that the amount the patient receives is not enough to prevent the disease entirely but is only sufficient in most cases to mask the symptoms. These patients usually take teaspoonful doses for a week or so and then discontinue it until they relapse. Brewer's yeast alone would probably cure pellagra if taken in half-ounce doses three times a day together with an adequate diet.

It is very probable that we all see cases of vitamin B deficiency without recognizing them. A great many people have peculiar ideas concerning their diet, thinking certain things are bad for them and voluntarily restricting themselves. Others are put on diets for one reason or another,—for example, the low protein, high carbohydrate diet prescribed for cardiorenal diseases requires more vitamin B than would an ordinary diet as vitamin B is essential for the metabolism of sugar. For the same reason vitamin B should be prescribed in diabetes. The entire complex should be prescribed in those ill-defined cases characterized



by anorexia, loss of appetite, nervousness and constipation.

I have had several cases in which nicotinic acid had a remarkable effect on stomatitis. The mouth and intestinal tract were symptom free after one week, but there was very little effect on the dermatitis, although it was somewhat improved. One patient also had a severe polyneuritis; there was tremor of the lips and tongue and she could not protrude the tongue from her mouth. Her feet were so painful that she could hardly walk. The polyneuritis was not in the least improved by the nicotinic acid. The second week 10 mg. of thiamin was given daily and a preparation containing the whole B complex. One week later she was able to protrude her tongue and could walk without much difficulty or pain. The dermatitis healed rapidly and has almost completely disappeared. As I have stated, the dermatitis was already improving and would probably have cleared up, but healed much more rapidly the second week than it had the first. One peculiar thing is that the symptoms subside much more rapidly than the physical signs. The tongue remains red and the atrophy is still very noticeable but subjectively they are symptom free.

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#### DISCUSSION

*Dr. Rothwell Lefholz, Miami:*

Doctor Wilson has very nicely summarized the most modern management and treatment of pellagra. Our knowledge of the clinical aspects of this disease is by no means recent, pellagra having been first accurately described by the Spanish physician, Casal, in 1735. Through the years into this century nothing of note was accomplished in the direction of its actual cause and logical treatment.

The literature indicates that the first definite outbreak of pellagra in this country was reported in 1907. It is not denied that it may have prevailed prior to that date to a considerable degree, but without definite recognition. Since 1908, however, it has been repeatedly reported from all the States in the Union, but has always been especially prevalent in the region south of the Potomac and Ohio rivers.

Its treatment had always been quite unsatisfactory until about eight years ago. Almost innumerable foods and drugs were known to afford clinical improvement, but a recurrence was to be expected. With the isolation of the vitamin B complex and nicotinic acid, the satisfactory experimental results and the, thus far, apparently satisfactory clinical reports from medical centers where the disease is particularly prevalent, we seem to be on the verge of another revolutionary change, as far as this disease is concerned. As recently as 1931, the literature stated that the cause of the disease was unknown and the mortality rate ranged from 30 to 60 per cent.

Prior to the era of treatment outlined by the author, the disease could not be properly handled outside a well organized hospital and, at best, the course of treatment in those who survived often extended over a period of weeks or months. Now the results indicate that in a majority of cases the patient may make almost miraculous improvement in a few days, thereby reducing his hospital stay, and the mortality rate has dropped to between 5 to 10 per cent. However, I don't think the question of recurrence is settled yet.

Should our newer concepts prove, by pharmacological refinements and education of the public, to be as well grounded as the results to date indicate, and if pharmaceutical houses will refrain from exploiting preparations of undetermined potency and if they will reduce their prices to within the means of the human strata so affected, I dare say that pellagra bids soon to hold a rank with the diseases of lowest incidence in the United States.

*Dr. G. C. Bottari, Tampa:*

The treatment of pellagra is a rather large subject to cover in such a short time, and I think Doctor Wilson has done it masterfully in his timely, precise and practical paper.

Casal, a Spanish physician, in 1735 first described this new disease called Mal de La Rosa or Rose sickness. Frapolli, an Italian physician, in 1771 named it pellagra from pellis (skin) and agria (affection). Pellagra, known as South's hard times disease because it follows slumps in the cotton market and other economic disasters in Dixie, comes in the orbit of the Welfare Agencies as much as in the interest of the internist, the dermatologist and neurologist. We have to consider it as a multiple deficiency disease in analyzing the facts that the peripheral neuritis responds only to vitamin B<sub>1</sub>, and that the pellagrous dermatitis and the general well being of the patients to the nicotinic acid and well balanced diet.

In treatment of genuine pellagra we have to consider the nicotinic acid diet deficiency, but we should not overlook the lack of absorption due to intestinal parasites, especially ankylostoma duodenale. This explains why some members of a family sharing the same food are victims of pellagra, while others are not. This is really not a disease of the poor because the rich also are subject to the evils of this intestinal parasite.

The value of nicotinic acid is less effective in pellagra as seen in the North where the disease is often the result of alcoholism, than in true endemic pellagra of the South.

The brilliant response of pellagra to nicotinic acid and derivants is an excellent therapeutic test to show the presence of this infirmity, and a good many cases classified as toxic psychosis and schizophrenia could be ruled out.

Nicotinic acid is a constituent of food, and anti-pellagra foods as yeast, wheat germ and liver are rich in nicotinic acid; corn meal, molasses, fat meats, etc., contain little of it, if any.

Nicotinic acid has been given also in radiation sickness, from 200 to 1000 mg. a day in fractional doses, and has proved miraculous in prompt cessation of nausea, vomiting, anorexia and headache. Doctor Spies of Cincinnati and Doctor Stone of Birmingham report good results in groups of patients with chronic con-

stipation without pellagra and in which there was a striking return of the bowels to normal.

Coramine is another substance used in the treatment of pellagrins and the effects are about the same as those of nicotinic acid, the cardinal symptoms of active pellagra, i. e., glossitis, anorexia, symmetric dermatitis, diarrhea and dementia, subside promptly.

Doctors Ruffin and David Smith report in a series of cases that dermatitis and sebaceous gland changes are more resistant to treatment of nicotinic acid than to liver extract.

A word of caution should not be overlooked about the use of this agent, especially considering the large doses used (Gm. 1, 5). The toxicity of the product has not been brought out, and the flushing of the face and neck almost immediately after administration, nausea, vomiting and severe nervous disturbances, are warnings to the clinicians. The circulatory effects, nausea, vomiting and other symptoms, seem to demonstrate that nicotinic acid shares the same effect and dangers of nicotine from which it may be removed.

Another clinical point to illustrate is: when will we consider the patient well? Is it when the improvement of the patient's well-being is associated with subsidence of dermatitis, glossitis, anorexia, diarrhea and mental symptoms without relapse after exposure to sunshine? Harris of London, Mack of New York, Spies and Ruffin are not of the same opinion. When we look at the violently demented pellagrins restored to sanity within from one to six treatments with nicotinic acid; when we contemplate the magic effects on the symmetric, typical dermatitis and other alarming symptoms, we cannot hesitate to further study the effect of this wonderful drug.

Sulfanilamide was the most important drug introduced in the medical practice in 1937. The palm for 1938 must go to nicotinic acid for treatment of pellagra.

*Dr. L. L. Whiddon, Ft. Pierce:*

This subject of pellagra has been a pet of mine for about twenty-five years. I have read papers in Georgia and Florida several times on this subject.

Although pellagra has been reported for many years we must say that it is a disease of civilization. If it is a disease of civilization, let us talk about the things that civilization is doing that are causing pellagra. Civilization is trying to do three things: trying to please the ear, eyes and taste. Let us see how we are making mistakes along that line. God, in His omnipotent preparation of man made three requirements of the human body: (1) we, being warm-blooded animals, that warmth must be kept up; (2) put up reserve flesh for a fasting period and (3), replace lost energy.

God did not forget in making these three requirements to supply each requirement with a definite food. The food for keeping the body warm is carbohydrates. I expect criticism on this because I have stood up before the State Association once before and said that I was at the point where I was willing to refute science in saying that carbohydrates were our energy food. They are not! Carbohydrates supply heat to the body only. We have been told in physiology that the heat was the strength or energy of the body. Science does not say it is, but it says that we presume it is. I can presume as well as any one. They have confused heat in the body with heat in an engine. Heat in an engine is energy after it is confined, but you could build a fire all over the engine; if you did not confine the heat, there would be no energy. Heat in the body is not confined; therefore, it is not energy. If carbohydrates are to keep the body warm, we certainly don't need them much in this climate.

Not only did God give us a food for each requirement but He did not forget to give us a digestive juice for each food, excreted by three separate digestive organs. Fats in combination with carbohydrates are to put up reserve nourishment for the fasting period. When first put on earth man did not have breakfast, dinner and supper. He probably had one meal a week or in

two weeks,—only when he could catch it. Then he needed to build up reserve nourishment so fats in combination with carbohydrates did that then. Do we need them now? We have breakfast, dinner, supper. We have no fasting period; therefore, we don't need to put up much reserve flesh now.

Then He gave us protein for our energy food, for our third and most important requirement. The fact is that every minute of our lives, every time we blink an eye, every time we think, every time we move, every time our heart beats, and every time we breathe we are losing energy. This must be replaced by proteins. Now we are going to the extreme in eating carbohydrates; that is civilization's grand mistake which is causing pellagra. We have grown fat on carbohydrates and starving for proteins. Let us quit eating carbohydrates and eat more ham, meat and liver,—and we will not have to use nicotinic acid.

Nicotinic acid is wonderful for an initial symptomatic recovery but you must correct your patient's diet if you are to have a lasting cure.

*Dr. J. Frank Wilson (Concluding):*

I wish to thank the gentlemen for their comments on this paper.

I agree with Doctor Whiddon on the importance of a proper diet. However, there are people who cannot procure it. The majority of cases seen are on relief and usually get food tickets of about \$2.25 a week per person and this amount will not pay for enough food of high protein value. My paper is primarily concerned with the treatment of patients who have already developed pellagra and is not concerned with its prevention.

## THE THYROID AND ADRENAL GLANDS AS FACTORS IN THE CONTROL OF FEVER

HEAT REGULATION AND CLIMATE

N. L. SPENGLER, M. D.

Tampa

The adrenals of all mammals which have been investigated so far, present at birth the complete apparatus of the fully developed adult adrenal. This is not so in the human adrenal. It is at birth a large organ with a smooth regular surface. The medulla is small and contains practically no adrenalin at birth; however, the embryonic gland from the eighteenth week onward contains considerable amounts of adrenalin but not before that date. It is interesting to note that a definite use in heat production beginning in the second week of life, may be related to the process of involution of the adrenal gland.

A process of this kind offers ample opportunities for abnormalities to occur. It has been noted in a cretin that the formation of the medulla of the adrenal is inhibited although the connective tissue formation has commenced. The suprarenal of a brainless child

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develops in the same manner as that of animals. In the adrenal of infants dying in the first three months after birth with the symptoms of marasmus, an imperfect development of the medulla was found. The material studied is not sufficiently large to draw definite conclusions. It is sufficient to suggest, however, that the pathology of the human adrenal during the first few months of life offers a wide field of study which is likely to yield interesting results.

The above facts have been borne out clinically by me in the administration of thyroid gland and adrenal gland substances in some of the otherwise unexplainable abnormalities found in the first ten months of life.

Much importance must necessarily be attached to the sudden change in the thermal environment occurring at birth. This change in environment is probably responsible for initiating this involutionary process by inducing the intense hyperemia which excites the connective tissue reaction in the adrenal caused by hemorrhage into the adrenal. If the above conclusions are correct, it seems possible that the process may take an abnormal course if the stimulation by the thermal environment is either excessive or inadequate, that is to say, if the infant is kept too warm or too cold.

There is also the possibility that dietetic errors may be responsible for abnormalities in the process. Several observers have shown that both vitamin B deficiency and chronic starvation produce changes in the adrenals of animals and children suffering from marasmus. It is not unreasonable to suppose that such factors, if operative during the first weeks of life of an infant, would interfere with the normal course of the process above described, which is peculiar to the human race. An excessive connective tissue reaction or an imperfect transformation of the cells destined to form the medulla, may cause some of the obscure diseases of infancy which are classed together under the term "marasmus" and which are not obviously due to dietetic errors. I have used insulin in this class of cases, but not with very satisfactory results. I have used thyroid with good results and since I have added adrenalin, I am sure that I have had better results.

With the exception of respiration, all the factors concerned in the heat regulation of

warm blooded animals are under the direct control of the sympathetic nervous system and, therefore, subject to control by the functional activity of the thyroid and adrenal glands. Increased functional activity of these glands has the effect of stimulating the sympathetic. There is, therefore, both a nervous and humeral apparatus for heat regulation. Stimulation of the sympathetic increases metabolism and, thereby, increases heat production. While it diminishes heat loss through constriction of cutaneous blood vessels, it increases heat loss through stimulation of the sweat glands. This latter effect may be inhibited by constriction of the cutaneous blood vessels. In furry animals which cannot regulate heat loss by sweating, this function is taken over by the arrectores pilorum. It follows, therefore, that stimulation of the sympathetic, by increasing heat production and by preventing a compensating increase in the heat loss or actually diminishing it, produces a type of fever known as "sympathetic fever." Such a fever can be induced by increased functional activity of the thyroid and adrenal glands, even without the presence of bacteria.

Evidence is adduced that in many of the fevers due to bacterial infections, there is an increased functional activity of these glands. In fever, there is a change in body temperature or, as it may be called, the internal thermal environment, due to the stimulation of the thyroid and adrenal glands. Conversely, the functional activity of these glands can be brought to play by changing the external thermal environment. Exposure to cold which calls for increased heat production and diminished heat loss, stimulates these glands to increased activity. Exposure to heat diminishes their activity. The thyroid and adrenal glands represent, therefore, a humeral apparatus for the heat regulation of the body. This accounts for the physiological effects of climate. A bracing climate is one which stimulates the sympathetic and the thyroid and adrenal glands; a relaxing climate is one which fails to stimulate them. The work of Leonard Hill and Argyle Campbell has shown that one of the effects of a bracing climatic environment, such as open air treatment, is a rise in metabolism, but this does not account for the beneficial effects of such an environment. The explanation is found in the increased functional activity of the thyroid-



adrenal apparatus of which the rise in metabolism is one manifestation.

The above conception of heat regulation enables us to dispense with the idea of a heat center which has dominated physiological and pathological thought for such a long time. Since heat regulation is a function of the sympathetic, the so-called heat center is in the cells representing the central connections of the sympathetic.

Of even greater general significance is the fact that changes in the external thermal environment affect the activity and structure of organs like the thyroid and adrenal glands which have such a profound influence on the physical and mental make-up of the organism.

The process which takes place at birth in the human adrenal is at present an unsolved problem. So far as is known at present it is without analogy in all the other mammals in which the development of the adrenal has been studied. Man differs from all other mammals in the fact that his heat regulation mechanism is so imperfectly developed that he can only maintain his body temperature by the aid of clothing and artificial heating, except in tropical climates. Civilized man behaves, so far as his heat regulation is concerned, like an animal kept at an outside temperature of 33 C. Under such conditions the chemical heat regulation is practically eliminated and only the physical heat regulation remains effective, which controls the heat loss. For this work the activity of the sweat glands is of such importance in that their failure to work in a warm environment induces heat stroke. Every attack of heat stroke is ushered in by a failure to sweat, and this prodromal symptom occurs many hours before the rise of temperature begins, so that it is impossible to avert successfully every case of heat stroke by instituting treatment with wet blankets whenever failure to sweat makes its appearance.

There are animals that do not possess sweat glands except in certain restricted sites, such as the pads of the feet, and they cannot, therefore, increase their heat loss by perspiration. To this group belong the animals with a thick fur. This represents a difference of greater significance than is generally recognized. While man and those animals possessing a wide distribution of sweat glands are capable of withstanding temperatures greatly exceeding those of the body, animals without sweat

glands are not able to do so. Rats and mice die in a still atmosphere of 34 C. and the post-mortem findings are similar to heat stroke in man (deep engorgement of the lungs).

Man without heat and clothing would be unable to live in any but a tropical climate, partly because his hairless skin gives him little assistance in preventing heat loss, and partly because his chemical heat regulation is less effective. The evolution of man, therefore, could have taken place only in a tropical climate. Sir Arthur has illustrated clearly the importance of two endocrine organs in the process of evolution. Man by the use of clothing and heat has made himself master of all climates, but climate affects him mentally and physically to a much greater extent than is generally supposed. Ellsworth Huntington has studied the effects of changes in weather on man, and has established definite variations. Both mental and physical activity reaches pronounced maxima in the midsummer and midwinter. Changes in temperature, provided they are not too great, are more stimulating than uniform temperature. In the temperate climates, a fall in temperature is more stimulating than a rise and people are not so efficient on fine days with a clear sky as on a cloudy day and after a storm. The greatest efficiency in physical and mental activity is found with a mean temperature lying between 50 and 60 F., and it falls rapidly as the mean temperature rises above 65 F. On the American continent such a climate is found in a broad belt running parallel with the Canadian border and comprising Southern Canada and the eastern and central states and also a narrow stretch on the Pacific Coast from British Columbia to California.

Huntington also claims that the shifting of climate is the cause of shifting of centers of civilization except in regions where the climatic stimulus is great. The observations on the thyroid adrenal apparatus supplies an interesting relationship between climate and civilization. It is interesting to know that a change from a warm to a cool environment was found to be a greater stimulus to the adrenal gland than continually cool environment. The fact that the activity of the thyroid and adrenal glands are subject to climatic conditions enables us to understand the effects of climate on man. For man, at any rate, these glands are not merely regulators of

metabolism, of heat production and heat loss. Their functional state affects his physical activities and colors his mentality. We need only to think of the degradation of intelligence which accompanies the earliest onset of myxedema, and the restoration to normal mentality through the administration of the thyroid gland. These pathological conditions form a counterpart to the depressing effect of a warm moist climate with little change from day to day, because it fails to stimulate the thyroid-adrenal apparatus and through it the sympathetic.

Conversely, the cool, variable climate, which we have learned to associate with the fullest development of human activities, provides a continued stimulus to the endocrine organs and the sympathetic.

The same explanation applies to the relation between climate and health. Why is the resistance against certain bacterial infections, such as tuberculosis, increased by a suitable cool, dry climate, and by measures such as open air treatment, hydrotherapy, and the like? Hitherto, we have been told that these conditions increase metabolism. The beneficial effects of metabolism can be increased by other measures such as vigorous muscular exercise but then it is likely to be harmful. The answer is that those measures are beneficial that stimulate the thyroid-adrenal apparatus without exhausting it, and this strengthens what we have seen as one of the normal reactions of defense of the organism against many bacterial infections. A warm, moist, monotonous climate weakens resistance against infections not because it reduces metabolism but on account of the continual absence of a stimulus to the thyroid adrenal apparatus and the sympathetic. During the influenza epidemic of 1918 the severity of the disease varied greatly from place to place in the United States. On comparing the deaths from influenza and pneumonia with various environmental factors it was found that the severity of the disease depended on the weather more than upon any other known factor. (*Nat. Research Council of the U. S.*) The epidemic was more severe in the warm parts of the United States and those cities in the cooler parts which happened to be especially warm before and during the epidemic. Where people were weakened by hot, damp weather, the influenza became virulent; it spread with

great rapidity and it entailed a huge death toll.

The depressing effects of inefficient ventilation, which the work of Leonard Hill has shown to be due to a lack of cooling power and not, as was at one time supposed, to be an excess of CO<sub>2</sub> in the air or to other toxic substances, are similarly due to this lack of a stimulus to the thyroid-adrenal apparatus. Conversely, we have the intensely depressing effect resulting from exposure to cold with insufficient clothing and inadequate heating.

At the other extreme is the effect of a tropical climate on man. This has frequently been attributed to a progressive decrease in the basal metabolism. A European's metabolism in a tropical climate is no lower than that of the same European in the cooler climate of his native country. Nor is there marked difference between the basal metabolism of a European and a native who is better able to withstand the climate than the European. There must, therefore, be some factor, in addition to the lack of stimulus, which makes the European less fitted to adapt himself to a tropical climate. As long as the thermal environment provides an efficient stimulus to the thyroid and adrenal glands, they are not only actively secreting their specific hormones but are as actively forming them. When thermal environment is absent, the formation and secretion are inhibited to the extent that the medulla of the adrenal does cease to contain adrenalin. There is a possibility that an abnormal accumulation in the blood stream of thyroxin and adrenalin may produce pathological results. There is a close relationship between adrenalin and pigment and this is seen in disease of the medulla or in Addison's disease when formation of adrenalin is impaired and pigment is deposited in the skin. The pigmentation of the races living in tropical climates may be the method by which the organism disposes of the material which would otherwise be used for the formation of adrenalin. In the white race this method of excretion of the excess of adrenalin is not so well developed and this may be one of the reasons why the white race is less fitted for a tropical climate.

"It is safe to say that there is hardly a single bodily function that is not directly or indirectly influenced by these glands. They are



concerned with differentiation of tissue, with nutrition and growth, with sexual activity and with mental development. In brief, they are bound up with all development, physical as well as mental."

903 Tampa Theatre Building.

## DISCUSSION

*Dr. J. R. Boulware, Jr., Lakeland:*

The essayist is to be congratulated on bringing to us this very interesting and instructive paper. As I looked back over my text books on the physiology of heat, I found the old concept of a heat center in the brain was taught, but never definitely proved. Doctor Spengler has shown us that a more rational explanation is found in the thyroid-adrenal sympathetic system.

He has brought out the inter-relationship of the external temperature and the thyroid-adrenal sympathetic control of the many important body functions.

But some of the statements made are still slightly controversial. Talbot, in 1936, quotes the work of Martin who found that on a trip to Australia his own metabolism fell 12 per cent on entering a hot climate and raised again to normal on reaching cool trade winds. Also, Mason found similar effect in metabolism of European women in temperate climate and in India. Thus we find that geographic and climatic conditions do affect metabolism. This would seem to indicate that there is an effect of climate on the thyroid-adrenal sympathetic system.

There is no definite agreement among the writers on the involution of the adrenal gland. Some contend that this involution is complete in three months and others in one to two years. The fact remains that it is fraught with potential abnormalities; that many things such as abnormal heat and cold, vitamin B deficiency, etc., as described by Dr. Spengler, may affect this gland and give us many acute problems of obscure nature found in many children under one year of age.

I would like to ask Doctor Spengler if he would tell something of how he administers adrenalin in some of the cases referred to, whether by hypodermic several times a day, and the results obtained.

*Dr. Frank S. Adamo, Tampa:*

The more I listen to studies of the endocrine, the more complicated the subject becomes. Of course we know that there are certain sympathetic fevers in which we do all the tests known to find the cause of the fever and we find nothing to which we can attribute such fevers.

I still think perhaps that there is a center for heat in the brain. And I think that all of the sympathetic system is very closely connected with the central nervous system.

Dr. Max Peet of Ann Arbor reported a case with temperature in which they did a postmortem and found a tumor of the hypothalamus. Of course it is true that we have certain cases that go on to autopsy in which we find no pathology to explain such deaths.

I think the suprarenal glands must have a great deal to do with the thyroid and the brain. Doctor Crile and his assistants carried on phylogenetic studies with reference to the adrenals and thyroids of lions and human beings. They found that in the lions the adrenals are twice the size of the thyroids, while in the human being, the opposite is true. Perhaps it is due to the fact that the lion requires great strength in his struggle for existence. In man, in which the intellect undoubtedly attains the highest pinnacle, the thyroid becomes larger. The living organism and even tissue has a great range

of adaptability, and so it is possible that the anatomical changes in these glands cause changes in physiology rather than the latter causing changes in the glands.

As I say, I enjoyed the paper very much and I hope that more studies will be made on these cases so that we may learn more about the endocrine system.

*Dr. Nathaniel L. Spengler (Concluding):*

The object to be attained by endocrine therapy in endocrine dyscrasias is to bring about a balanced hormone output from all the endocrine glands. It is better never to speak of a condition as being one of hyposecretion or hypersecretion of some particular gland because it creates the idea of substitution therapy or reduction therapy and the picture of what has taken place or will take place in the hormone output of therapy is lost.

The endocrine glands must maintain a proper balance if we are to live lasting and normal lives. Of course you may have hypofunction of any endocrine gland or you may have a congenital deficiency of a developmental nature, or a trauma, or a diseased gland, all of which would give similar symptoms. This can only be explained by the time in life it presents itself, its onset, the body's variation from normal anthropometry, mentality and behavior characteristics, and certain laboratory findings which must be valued with reservations. There is not a single diseased condition of the body that does not have its endocrine aspects, because they are bound up in all physical and mental activities. Long drawn-out convalescent periods from operative and diseased conditions are often the result of failure of the endocrines to regain proper balance. Cell sensitivity, receptivity and utilization are essential to proper nutrition. Without these essentials, inanition gradually results and we say too much loss has occurred and the patient must die. This condition is often due to endocrine imbalance or anabolic failure. If the catabolic side fails, we have rapid or gradual increase in size, which results in various types of dystrophies. I have seen the very thin and very large individuals return to normal proportions under the same endocrine therapy, proving that endocrine balance can be produced and maintained only by a proper relationship which is dependent on normal function of all glands.

The best approach is by, first, stimulation of the activity of all the body cells and, of course, this includes the endocrines. Next note carefully all things that influence the endocrines and, when satisfied that all have reached their maximum efficiency, then you are in position to begin substitution therapy to correct remaining dystrophies. This requires time and patience both on the part of the physician and patient. I am an exponent of uniglandular therapy, first in the form of stimulating hormone, then making substitutions of various uniglandular products, discontinuing, increasing or decreasing their intake at various levels with the object always in view of reaching and maintaining a normal hormonal utilization by the body which will maintain a normal functioning human being.

My object in presenting this paper is to show the important part that endocrine dyscrasias play in all things medical and to create within the minds of medical men the importance of studying all patients from an endocrine point of view. For years I have recognized this fact and I am thoroughly convinced of its importance in pediatrics and in adults. It is in early life we must recognize and treat endocrinopathies if we want the best results. I am convinced that endocrinology is a most important part of the field of the pediatrician, because most of our childhood problems are endocrine, and the same can be said of adults.

*References:* I have tried to give credit where it is due but there are so many repetitions and duplications and the literature is so voluminous that it is impossible. However, I do wish to give full credit to Cramer of Edinburgh and the Imperial Cancer Research Fund.



## MYOCARDIAL INFARCTION

### ELECTROCARDIOGRAPHIC CHANGES

#### AND NECROPSY FINDINGS

JERE W. ANNIS, M. D.

Lakeland

The history of coronary occlusion with resultant myocardial infarction is one which is most familiar. It is because of its frequency as well as the rapid strides made in its diagnosis that I have elected to review briefly the electrocardiographic changes in this disease and, more specifically, in three recent cases in which necropsy was performed.

Incidentally, in connection with the first case, it is well to recognize the importance of embolism as a complication of cardiac infarction. Blumer<sup>1</sup> has shown that intracardiac thrombi are present in 50 per cent of cases, with clinically recognizable embolic phenomena in 14 per cent.

CASE I: A female, aged 70 years, was admitted to the hospital May 3, 1938, with a history of recurrent attacks of gaseous indigestion for several years. During the past two days nausea and vomiting had become severe and the patient was unable to retain any appreciable amount of food. This was accompanied by a severe burning sensation in the substernal region. Hospitalization was precipitated by a severe attack of precordial and substernal pain with radiation to both arms and accompanied by nausea and vomiting. There was a definite preceding history of pain on effort or exertion. The patient's past history was essentially negative except for malaria and typhoid fever many years previously.

Physical examination revealed a well-nourished, white female, apprehensive and in severe pain. Eyes essentially negative except for retinal sclerosis, grade II plus, on funduscopy. Nose and throat negative except for tonsillar sepsis, grade I. Thyroid negative. On percussion, the left border of the heart was just inside the nipple line and there was no evidence of enlargement to the right of the sternum. There was perceptible widening of the area of dullness over the aortic region. Rhythm was totally irregular; apical rate 168, radial pulse 116. No definite murmur heard but the rapid, irregular apical rate made auscultation difficult. Blood pressure: 140/92. Examination of lung fields revealed only a few moist rales and slightly increased pitch in breath sounds over the left base posteriorly. On abdominal examination, the liver edge was palpated 2 fingers' breadth below the costal margin; abdomen otherwise negative. Extremities showed no evidence of edema but peripheral sclerosis, grade II plus.

The patient was kept at absolute bed rest with morphine in sufficient amounts to insure good relaxation. Convalescence was uneventful at first but later, on the 15th day after admission, she underwent another sudden, severe attack of precordial pain and died shortly thereafter.

At autopsy, the heart showed beginning adhesive pericarditis over the anterior surface with an area of softening and old infarction about 3 x 4 cm. in the anterior apical region of the left ventricle. There was a smaller area which appeared very slightly softened and dis-

colored higher up on the anterior wall. On opening the heart, the area of infarction in the left ventricle was seen to be situated in its anterior apical portion but involved chiefly the interventricular septum. There was a large mural thrombus, 3 x 3 x 4 cm., lodged in the infarcted area with a thinning and beginning aneurysmal dilatation of the wall. The right coronary artery showed sclerosis and narrowing of the lumen, grade III, in spots, but was open throughout. In the anterior descending branch of the left coronary artery, about 5 cm. from its origin, there was complete occlusion of the lumen by an old organized thrombus. (Fig. 1).

Before going on to the electrocardiograms in this case, let us look back momentarily over the subject we are about to discuss. There are several anatomical and pathological facts to be recalled:

1. The anterior descending branch of the left coronary artery supplies the anterior apical part of the left ventricle and the interventricular septum;

2. The circumflex branch of the left coronary artery supplies the left half of the posterior portion of the basal three-fifths of the left ventricle; and

3. The terminal portion of the right coronary supplies the posterior part of the interventricular septum and the posterior basal portion of the left ventricle.

Pathologically, we are dealing with an ischemia of the cardiac muscle, usually from a thrombosis in one of these vessels, with the frequent development of mural thrombi and localized pericarditis. Acute infarction is practically entirely limited to the left ventricle either in its anterior apical or posterior basal portions and to the interventricular septum. Exhaustive reviews of the subject by Barnes,<sup>2</sup> Wolferth,<sup>3</sup> and Wilson<sup>4, 5, 6</sup> have established that it is the infarcted area rather than the occluded vessel which produces the characteristic electrocardiographic changes. This is further emphasized by Katz<sup>7</sup> who says that the "electrocardiogram is a record of events in favored rather than in all regions of the heart. Currents due to injury and affecting these favored regions are revealed, but those in other areas may be missed."

The use of the electrocardiogram as a diagnostic measure is still empirical—yet its aid is often invaluable, especially since the strict confinement of the patient with proved myocardial infarction is not to be lightly imposed upon one in whom the diagnosis is in doubt.

Likewise, the localization of the infarction may be said to be an academic question, yet it is the accumulation of large amounts of this

Read before the meeting of the Southwest Medical District, Bradenton, September 29, 1938.



Fig. 1. CASE I. Left ventricle showing large mural thrombus in situ.

carefully collected "academic" data which may, with our ever-increasing knowledge of the subject, eventually add greatly to the accurate prognosis and more successful treatment of this condition. It is for these reasons that we must utilize every available adjunct in the accurate diagnosis of one of the most common causes of death today.

Herrick<sup>8</sup> in 1919 and Pardee<sup>9</sup> in 1920 first described the electrocardiogram of acute coronary occlusion, the latter attempting to localize the infarct. Barnes and Whitten<sup>10</sup>, and Parkinson and Bedford<sup>11</sup> enlarged and amplified these characteristic changes in the standard leads until there are now established two definite types of electrocardiographic pat-



terns, the one associated with anterior apical infarctions and the other with posterior basal ones.

Summarizing and tabulating these changes in typical cases, we find first the Q1-T1 tracing seen with infarction of the anterior apical portion of the left ventricle in which we see:

1. A prominent broad Q wave in Lead I which may be the sole deflection of the Q-R-S group and is always followed by a low R summit. The Q is absent in Lead III.

2. A deep S wave in Lead III.

3. An elevated rounded "cove plane" RS-T segment in Lead I with a reciprocal depression in Lead III. There is a high take-off of this S-T segment from the Q-R-S complex in Lead I.

4. Finally, the development of a sharply inverted and pointed T wave in Lead I with a sharp upright T 3. Lead II usually follows the characteristics of Lead III but may resemble Lead I.

In the Q 3 T 3 pattern of posterior basal infarction there is an exactly reversed situation:

1. Marked Q deflections in Leads II and III, often large and W-shaped.

2. An elevated rounded RS-T segment in Leads II and III with a depression in Lead I.

3. A sharply inverted V-shaped T 3.

Any or all of these changes may be present in cases of myocardial infarction. Wilson<sup>12</sup> and others have pointed out that while variations in the individual waves of the initial and final ventricular complexes may be seen in conditions other than myocardial infarction, the complete picture when present is diagnostic. In this regard, it is well to emphasize the observation of Akesson<sup>13</sup> that Q 3 waves and inverted T 3 waves may occur in normal subjects. For this reason progressive changes in a series of electrocardiograms are vastly more useful than any one single tracing.

*Accuracy of Localization:* In the vast majority of cases, necropsy shows anterior apical infarct with Q 1 T 1 type of electrocardiogram and posterior basal lesion with Q 3 T 3 types. Exceptions apparently occur, but most cases in literature are not convincing. There can be no doubt that there are not infrequent instances of infarction in which the three standard leads are normal or nearly so and in which the fourth or precordial leads will

furnish an unequivocal diagnosis. However, it is my belief that these cases are less common than is generally supposed and that more careful perusal of the standard leads would be rewarded with a higher percentage of positive findings. This is certainly true of those cases in the literature, many of which, though purportedly negative, show rather characteristically typical changes. In this respect the attention which Barnes<sup>2</sup> and others have called to the upwardly rounded S-T segment is of the utmost significance.

Frequently, multiple infarcts complicate the picture and lead to erroneous diagnoses. Illustrative of this point is my next case.

CASE II: A diabetic woman, 67 years old, had hypertensive and coronary disease of obviously long standing. While in the hospital for amputation of a gangrenous extremity, she had a severe attack of prolonged substernal pain, nausea and vomiting. Electrocardiograms 12 hours later showed a rather typical picture of a posterior basal infarction. Death occurred 3 hours later and at autopsy, a large, recent, anterior apical infarct and an old, healed, posterior basal one were found. (Fig. 2). Unfortunately, this was on the first day of hospitalization and an electrocardiogram had not been taken before the attack, but the chief changes were obviously due to the old rather than the recent infarct.

A third case serves to emphasize the value of progressive changes as observed in serial tracings.

CASE III: This patient was an 80 year old female with pernicious anemia who had typical symptoms of coronary occlusion while in bed in the hospital. Tracings were made daily for 8 to 10 days. At first, definite evidence could not be established, but the progressive changes eventually indicated a posterior basal type of occlusion, a fact which was later proved at autopsy. (Fig. 3).

#### FOURTH OR PRECORDIAL LEADS

In an effort to obtain more exact localizing evidence of infarcts, numerous experiments have been made in the past several years with leads taken from the precordium. Wolferth and Wood<sup>14</sup> in 1932 were the first to point out that these leads may show the typical Q R S-RS-T and T wave changes in coronary thrombosis when the standard leads are equivocal. Since then there have been countless variations and innovations in the manner of taking these leads and it is only recently that a special committee<sup>15</sup> has attempted standardization and simplification of them. Leads may be taken from five or more points across the chest wall and while information from a single precordial lead is sometimes misleading, it is recommended that if, to save time, one only is taken, it be taken with the precordial elec-



trode over the apex. It is also recommended that the galvanometer connections be such that an upward deflection in finished curve be indicative of a relative positivity of the exploring electrode, thus keeping the normal configurations in accord with the standard leads.

Briefly, the signs of infarction in the precordial leads are the same as those in the conventional leads; that is, in anterior apical infarction:

1. In early stages, pronounced positive displacement of RS-T junction and RS-T segment.

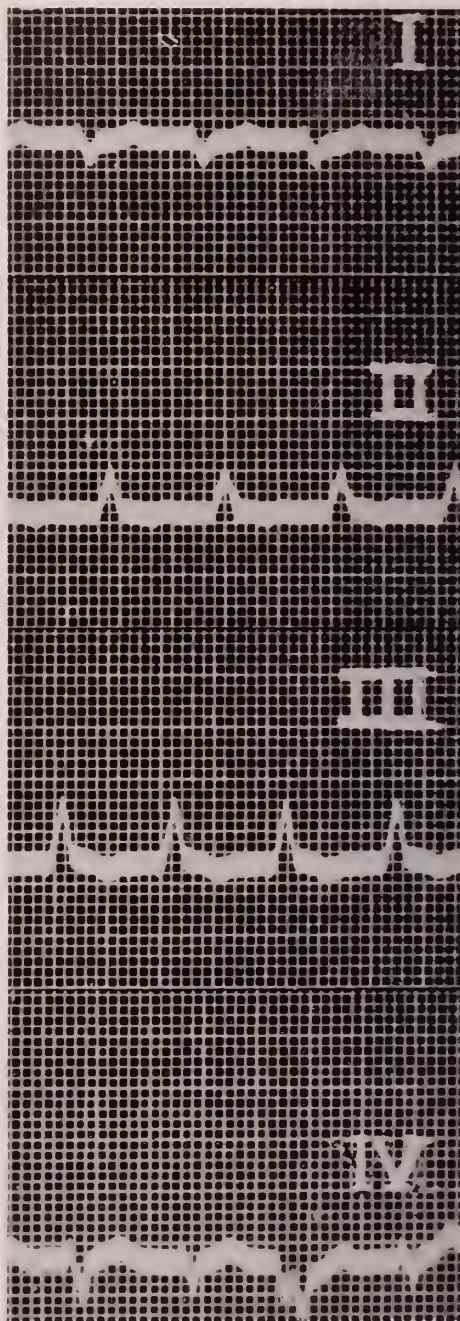
2. As RS-T displacement declines, a large, initial deflection Q and a large, pointed, negative T wave develop.



(a) Large recent anterior apical infarction.



(b) Small area of ancient posterior basal infarction.



(c) Electrocardiogram showing right ventricular preponderance, low voltage, depressed S-T segment Lead 1 with an elevation in Leads 2 and 3. There is a tendency to an exaggerated T 4 (Lead 4 is the Lead 4 F of the Committee for Standardization of Precordial Leads (15) unless otherwise specified.

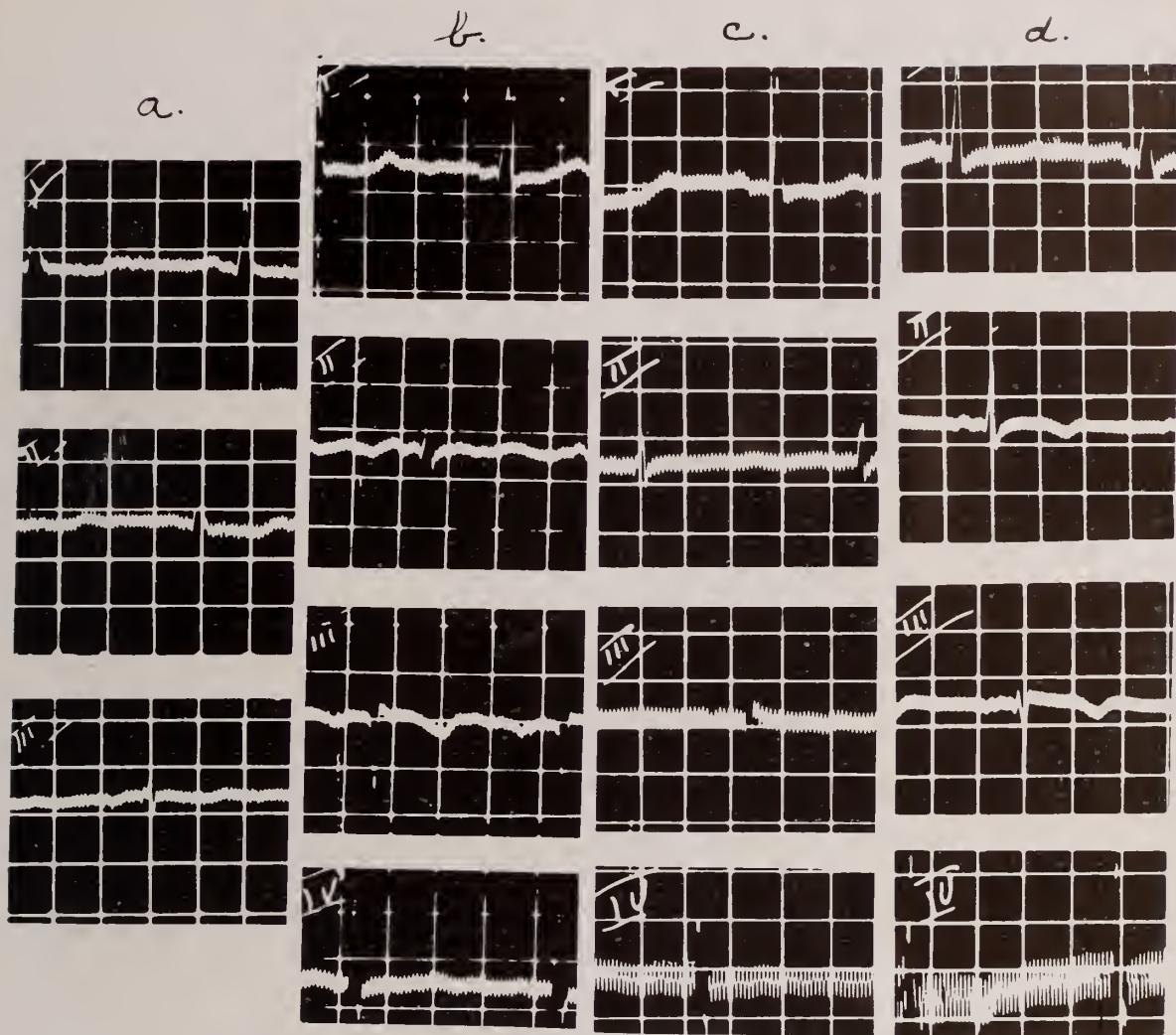


Fig. 3. TRACINGS IN CASE III.

- (a) Two weeks before occlusion showing isoelectric T 3, diphasic T 1 and T 2, left ventricular preponderance.  
 (b) Twelve hours after supposed occlusion. There is an isoelectric T 2, an inverted T 3 with a rounded RS-T segment, indefinite T 4.  
 (c) Forty-eight hours later. Similar to (b) but T 4 is more prominent and is upright. (This 4th lead is a Wolf-ferth lead).  
 (d) Forty-eight hours later. Inverted T 2 and T 3, upwardly displaced RS-T segments in leads 2 and 3, Inverted T 4 (4 F).

At autopsy several months later an old posterior basal infarction was found.

The Q wave often becomes the sole deflection of the Q-R-S group.

These two sets of tracings are not always most prominent in the same precordial leads.

In posterior basal infarction, the precordial leads are usually not characteristic due to the location of the lesion. There is a tendency to a negative displacement of the RS-T segment and to a high pointed positive T wave, but these are frequently unconvincing. I have the tracings of two other cases for com-

parison. The first two (Fig. 4) are of the first case reported and show changes indicating the anterior apical lesion which was found at the autopsy. The others (Fig. 4) are of a posterior basal type of infarction and show typical Q 3 T 3 changes. The patient is still living and in good health today, two years after his occlusion. In this regard, it has been pointed out that the more classical the electrocardiographic picture the better the prognosis and, conversely, the more atypical the worse is the prognosis.



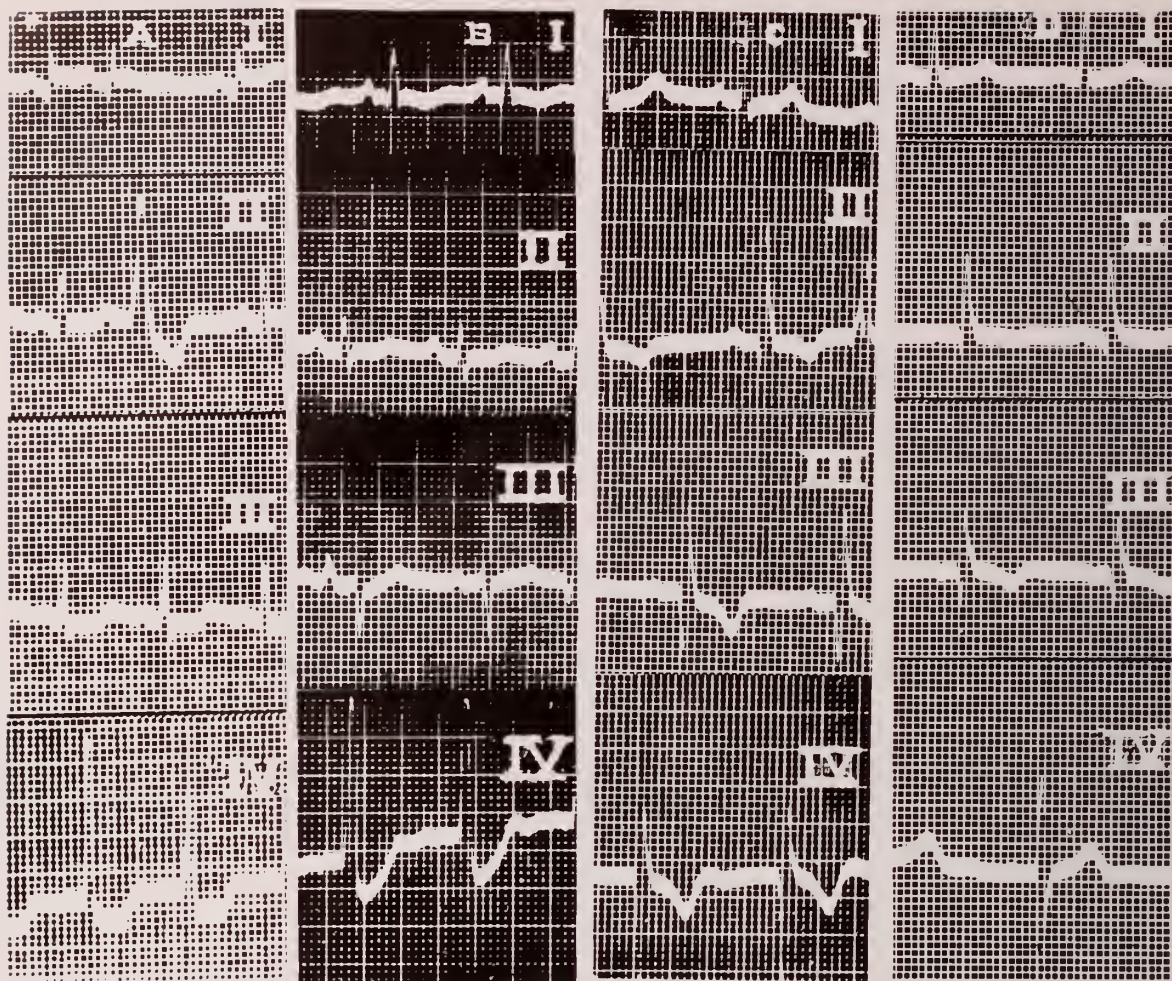


FIG. 4.

- (a) CASE I. Three days after infarction. Note Q 1, elevated RS-T segment in lead 1 and indefinite T 1 and prominent S 3. T 4 is isoelectric and RS-T 4 shows beginning restitution to its original negativity.
- (b) Same case 11 days later. RS-T 1 returning to normal, Inverted T 1, Deep S 3, Diphasic T 4 with increasing restitution of RS-T 4.
- (c) Typical posterior basal type of infarction (Case 4) Wolferth 4th lead—1 week after occlusion.
- (d) Same case two years later, with lead 4 F showing sharply pointed upright T wave.

Finally, it should be emphasized that the electrocardiogram is a laboratory procedure and that it should be so regarded in making a final diagnosis of the patient's condition; that it is unwise to make an unequivocal diagnosis of even myocardial infarction on the electrocardiogram alone; and that the tracing is best interpreted by the patient's physician or consultant, not by a laboratory.

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## SURGICAL CONDITIONS CAUSED BY INTESTINAL PARASITES

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When one meets an unexpected condition in the practice of medicine he is usually interested. When the same unexpected condition is seen a second time and still a third time within a comparatively short space of time, he would be an unusual person if he failed to make some sort of investigation.

Acute appendicitis is not an uncommon or unusual surgical condition nor is intestinal obstruction rare. Abscess of the liver, while more uncommon than either appendicitis or intestinal obstruction, is seen often enough to be kept in mind by all surgeons. Intestinal parasites, as the causative factor in either of these distinctly surgical conditions, may be forgotten by the surgeon, and thereby be the cause of an unexpected condition.

With this thought in mind, it having been brought forcibly to my attention by certain recent experiences, I wish to direct your thought briefly to three intestinal parasites causing surgical conditions.

The 1933 outbreak of dysentery following the Chicago World's Fair, for a time centered our attention on amebiasis. More recently a statement by Craig that probably from six to

ten per cent of the population of the United States is affected with amebiasis should cause us concern. Craig<sup>1</sup> bases his estimate on personal observations and the fact that sixty to seventy per cent of those infested with ameba do not give a history of dysentery of note. Fortunately, only a small percentage of the cases go on to develop liver abscess. Very interesting statistics are given by several investigators, notably the classic article by Kiefer in the *Philadelphia Medical Journal* of Feb. 21, 1903. Gessner<sup>2</sup> in 1932 reviewed 96 liver abscesses occurring in Charity Hospital (New Orleans) of which 56 were judged to be amebic with a mortality of 33.9 per cent. Ochsner and DeBakey<sup>3</sup> in 1935 based their outstanding essay on a review of 4,484 collected and personal cases, and they conclude that amebiasis with amebic abscess occurs much more frequently than generally has been supposed.

The disease as pointed out by Craig is not confined to the tropics and abscesses frequently occur without any history of previous diarrhea. Pain along the right costal border, with tenderness, fever, and unexplained enlargement of the liver is suggestive of hepatitis and abscess. Jaundice is not often a part of the picture but a rather greyish-yellow appearance is frequently noted. There is a characteristic x-ray appearance according to Miles<sup>4</sup> which is of value in locating the abscess and in determining its size. The complement fixation test devised by Craig<sup>5</sup> will be of value in a certain percentage of cases, while the aspiration of the chocolate brown pus from the liver is pathognomonic. About 89 per cent of these abscesses contain sterile pus, characteristic in its brown color. Ameba may be demonstrated in this pus which is in reality a necrotic fluid containing broken down liver tissue and blood cells. When there is a secondary infection there are likely to be staphylococci, streptococci or any of the pyogenic organisms present.

The symptoms of a typical amebic abscess or "tropical abscess" of the earlier writer, may be very definite and positive, but often are obscure. Fever and sweats are noted in about three-fourths of the patients. The fever is much like malaria but is more hectic and is not controlled by quinine. The sweats are not "night sweats" but can better be called "sleeping sweats." In chronic cases there

<sup>1</sup>Read before the Second Annual Meeting of Medical District B, Gainesville, October 27, 1938.

may be no fever. There is loss of weight and strength and appetite. The whole liver usually enlarges and can be demonstrated by percussion. It may push the diaphragm upward for several inches and when the abscess is near the lower surface it may extend considerably below the costal border. There may be edema of the skin over the site of the abscess and occasionally a fluctuating mass may be felt. There is not always pain, but usually there is tenderness and pain on pressure over the right costal border. The pain may be dull and heavy but as the abscess approaches the surface it becomes sharp. Usually it radiates to the right shoulder or scapular area. If the upper surface of the liver is involved there may be a pleurisy-like pain on breathing or coughing. Pleurisy with effusion is a frequent complication. A severe cough that is worse when the patient lies down suggests involvement of the upper surface of the liver. The patient usually lies on the right side with the shoulders drawn down and the knees up in order to relax the abdominal muscles and relieve the muscle tension.

With these typical symptoms a diagnosis should be made. The treatment consists of draining the abscess cavity and the administration of emetine for a long period of time. The drainage of the cavity by closed method or trocar aspiration has shown a marked reduction in mortality over the open drainage method. In Ochsner and DeBakey's series of cases open drainage mortality 19.5 per cent was reduced to 4.1 per cent in those treated by conservative closed drainage. The generally accepted statistics show a gross mortality of 47.2 per cent for open drainage against 6.9 per cent for closed.

Acute appendicitis in children is diagnosed rather less frequently than in adults. However, when it is diagnosed clinically the differential white blood cell count is often an indicator of the type of appendix one will find on opening the abdomen. Usually one has no great difficulty in making the diagnosis of appendicitis. A history of abdominal pain, at first more or less generalized and gradually becoming localized in the right lower quadrant, accompanied by nausea, vomiting and tenderness or rigidity of the abdominal muscles and an elevation of temperature, usually indicates an acute appendicitis. When to this

symptom complex there is added a negative urine analysis with a white blood cell count above ten or twelve thousand, a positive diagnosis is customary. Add to this picture a differential white count that shows an elevation of the eosinophils and one can suspect a hookworm infestation. The acuteness of the clinical symptoms as a rule does not permit delaying of operation until a stool examination can be made for parasitic ova. Hence, the diagnosis can be made positively only at operation. The appendix is most often quite red and injected and usually rather uniform in size. There has been noted a certain freedom from adhesions or plastic lymph about the appendix and as a rule from 3 to 8 hookworms will be discovered in the appendix when it is opened. Five such cases have been observed during the past several years. Post-operative treatment should always in these cases include the administration of a suitable anthelmintic.

Four cases of acute primary intestinal obstruction in less than six months should give anyone cause for concern. When all these occur in children of six years of age and less it assumes more importance, particularly from the standpoint of prevention.

Three cases of acute intestinal obstruction in children twenty to thirty months' old each, with no history of dietary indiscretion have been observed. Each case had a history of abdominal pain, colicky in character and recurring. The abdomens were soft enough to palpate but pain was complained of. Nausea and vomiting occurred in all cases with inability to pass feces or flatus as another symptom. Elevation of temperature was observed in one case and in each case a tumor mass was present in the left lower quadrant. The tumor, while suggesting and in a great degree simulating an intussusception, was larger and had a peculiar doughy feel when palpated through the abdominal wall. The clinical picture of obstruction was so complete and the degree of resulting toxemia so marked that immediate operation was resorted to. The possibility of an obstruction due to worms was considered prior to operation and in two cases definitely agreed upon. Textbooks tell of the various kind and number of worms that can and do get into a child's intestines, but until you have seen a small gut distended to three



times its normal size by a mass of a hundred and thirty ascaris lumbricoids, so tightly packed that even flatus cannot pass, you just haven't seen worms. Once the abdomen is opened and the cause of trouble demonstrated it is simply a matter of opening the intestine and removing the worms by grasping them with forceps one or more at a time. The mass can be milked from above downward to your opening just as you would push an orange into a Christmas stocking. The postoperative care of these patients is quite important, as frequently ileus develops and in small children this complication has high mortality. The administration of santonin and calomel is a standard procedure in all cases of ascaris infestation, but where an operation has been done, it should be withheld until convalescence has progressed for several weeks.

I would sound a warning against the administration of any anthelmintic followed by a drastic purgative in all cases of children suspected of having a heavy ascaris infestation. Such a procedure can result in the packing of a mass of worms so tightly that an obstruction results. In a case of incomplete obstruction due to ascaris, diagnosed by palpating of a tumor mass in the abdomen, and on the history of vomiting a 10-inch worm, satisfactory removal of the worms was accomplished by repeated high enemas and the administration of minute doses of oil of chenopodium.

#### CONCLUSION

1. Amebiasis is more prevalent than we used to think; it causes diarrhea in not more than 40 per cent of cases and, of these, possibly 20 per cent develop abscess of the liver that should be drained surgically, preferably by aspiration, and each case should receive emetine treatment after drainage.

2. Appendicitis in children, and adults, may be caused by hookworm infestation, and a preoperative diagnosis may be indicated by the number of eosinophils noted in the differential white blood cell count.

3. Acute intestinal obstruction can be caused by ascaris lumbricoids infestation. It can be produced spontaneously by the mass of worms and it may be produced by the administration of anthelmintics followed by purgative. Postoperative care of children is important.

4. A plea for careful treatment of patients with intestinal parasites is made to the end that we shall have fewer surgical conditions caused by intestinal parasites.

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*27 West Madison St.*

### ABDOMINAL FOREIGN BODY CASE REPORT

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Miami

There are several reasons for reporting this case. The foreign body removed was in the abdominal cavity for a period of either eighteen or twenty-one years. It is impossible to determine accurately the length of time as two abdominal operations were performed at three-year intervals. Another unique feature of this case, is the possibility, even probability, that multiple foreign bodies were in the abdomen. As the two surgeons who performed the previous operations have both been dead for several years and as the patient knows of her condition, it is perfectly safe to report this case without any untoward effects. The final reason for reporting this case is the hope that it will once again bring to our minds the grave responsibility we incur every time we open an abdomen and use small sponges without carriers or tapes with metal rings attached to them.

#### CASE REPORT

This patient was first seen on February 28, 1938, about 9 p.m. She complained of severe abdominal pain and vomiting. This pain began about six hours previously, was cramplike in character, located over the mid-abdomen and accompanied by vomiting. During a paroxysm the patient would double up from the severity of the pain. She vomited about ten times, the vomitus being watery and bile-stained but not of a fecal nature or odor. Her bowels moved the previous day, but since the onset of the attack she had had no bowel movement and had passed no gas. There had been many previous attacks of a similar nature while the patient was living in the north, but they always responded to medical treatment. There were no symptoms referable to the respiratory, cardiac, genito-urinary or nervous systems. The patient had enjoyed fairly good health, except for underweight, chronic constipation and attacks of intestinal colic.



The past medical history was naturally of extreme importance in this case and revealed that the patient had four previous operations. The first one was performed in 1917, the gall bladder, appendix and right ovary being removed. Following this operation the wound broke down and drained for four months, finally healing but resulting in the formation of a large ventral hernia. The second operation was in 1920 when the hernia was repaired. Following this second operation, the abdominal wall being solid, the attacks of abdominal pain and constipation persisted, being attributed to adhesions. These attacks, however, were never quite severe enough to demand operation. The third operation, a right mastectomy was performed in 1934 for chronic cystic mastitis. The fourth operation was performed in October 1937 when the left breast was also removed for chronic cystic mastitis. The last diagnosis has been confirmed by a report of chronic cystic mastitis from the pathologist. The past medical history was otherwise unimportant.

*Physical Examination:* The patient was a thin, adult female in acute pain; aged 48 years. Her pulse rate was 120; blood pressure 140-80; the skin was cold and clammy. The pupils reacted to light and accommodation; ocular movements were full and equal. The mouth was edentulous, otherwise normal as were likewise the throat and neck. The chest showed the smooth scars of bilateral mastectomy, with the skin soft and freely movable. One medium-sized gland was present in the left axilla. The lungs and heart were normal. The abdomen was tense, slightly distended, and a long scar extended from the costal margin almost to the pubis over the right rectus muscle. This was solid with no evidence of hernial protrusion. There was moderate generalized rigidity which became marked when a paroxysm of pain occurred. There was exquisite tenderness in the scar below the umbilicus in the appendiceal area. Peristalsis was quite active on auscultation, but later no peristaltic movement could be heard. No masses could be palpated and there was no evidence of femoral or inguinal hernia. Vaginal examination showed a nulliparous cervix. Due to pain, rigidity, and distention the pelvic organs could not be outlined satisfactorily. The extremities were normal and the reflexes active.

A diagnosis of acute intestinal obstruction was made and the patient was moved to the hospital. It was thought the obstruction was due to adhesions. An enema given returned with particles of fecal material from the lower bowel. A flat plate made by x-ray with the patient in the upright position showed considerable distention of the small intestines with fluid levels scattered throughout the abdomen. The roentgenologist confirmed the diagnosis of intestinal obstruction and considered the terminal ileum as the obstructed site. The blood count showed hemoglobin 94 per cent, red cells 4,600,000, white cells 18,000. Segmented nuclear leukocytes 82 per cent, juvenile leukocytes 4 per cent, and lymphocytes 12 per cent. The urine had a *sp. gr.* 1020, was amber colored with an acid reaction, negative for albumen and sugar. The microscopic study revealed 1 to 3 pus cells per high powered field, squamous epithelium, several hyaline and a few cellular casts.

*Operation:* This was performed the same night. Under cyclopropane anesthesia the old scar was partially excised. The great omentum was adherent to the parietal peritoneum at the point of entry, the site of the previous operations. Upon freeing it, the cecum and ascending colon were found to be moderately distended and a large portion of the terminal ileum markedly distended. There was a hard smooth mass, somewhat larger than a hen's egg, around which the loops of the terminal ileum were matted. On partial dissection this mass was found to have a very smooth, glistening capsule. In the process of dissection this capsule was nicked and cheesy caseous material exuded. At this stage it was thought to be a very large cheesy gland. Completing the dissection and breaking into the mass a sponge was discovered which had been left in at a previous operation. The intestines were freed and the obstruction liberated. They required no further atten-

tion, as they were in good condition. The raw area left at the site from which the sponge was removed was mopped with amfetin and 50 cc. of amfetin was instilled in this neighborhood just before closing the abdomen, in the hope of minimizing the formation of new adhesions. Owing to the tedious nature of the dissection and the unfavorable condition of the patient a complete exploration of the abdomen was not made.

*Postoperative Course:* An unusual postoperative temperature curve prevailed for the first five days. The highest temperature recorded on the first postoperative day was 99.6° F. and the temperature never went over 100° during this period. The pulse remained between 80 and 90 during this time. There was troublesome distention of a moderate degree for a few days, the bowels not moving satisfactorily until the third day. Prostigmine (therapeutic strength) seemed to have no effect at all. Vomiting occurred a few times during the first two days, but was controlled by means of the Levine tube. On the fifth day the temperature rose to 102° and the urinary bladder was found to be greatly distended, although the patient had been voiding freely and never required catheterization. 1500 cc. were removed by catheter. The urine at this time showed a heavy trace of albumen, several red cells, was loaded with pus cells and contained a large number of bacteria. Under treatment this condition subsided, the temperature reaching normal, and remaining normal three days later. The daily fluid intake was maintained between 3500-5000 cc., by means of intravenous infusion. The patient was discharged on the seventeenth day, the urine showing only 4 to 6 pus cells per high powered field. The incision healed by first intention, the appetite was good and the bowels moved regularly.

#### COMMENTS

This case illustrates that it is almost impossible to diagnose a foreign body in the abdomen when it does not cast a shadow in the x-ray. Many physicians treated this patient during the past twenty-one years for attacks of intestinal pain and vomiting, but the presence of a foreign body was not even considered.

The patient's husband and father-in-law, who are physicians were present at the operation in 1920 when the ventral hernia was repaired and are morally certain that the surgeon removed a sponge at this operation. However, he never admitted it to them. The history of the wound breaking down and draining for four months would tend to corroborate this. As this surgeon has been dead for several years I have been unable to confirm it.

The sponge in situ was entirely walled off and encapsulated. Despite the long period of time it showed no calcification either grossly or in the x-ray film. It also apparently showed very little tendency to ulcerate into the intestines. While it was reduced to a mushy mass with thick inspissated cheesy material, the fibres showed very little destruction. Apparently its main effect was in the formation of adhesions and in acting mechanically as a foreign body.

The patient is now enjoying fairly good health, being free from abdominal pain, but still having constipation of a moderate degree.

This case illustrates the grave danger of using small sponges that are not on a carrier or taped with a metal ring attached.

307 Ingraham Building

## ERYTHEMATOUS LUPUS IN NEGRO YOUTHS

### CASE REPORT

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Jacksonville

The two patients, both with typical clinical facial lesions of erythematous lupus, whose cases are here reported were seen at about



CASE 2

the same time in the skin clinic of the Out-patient Department of the Duval County Hospital, in February, 1939.

CASE 1. A Negro boy, aged 12, had a facial involvement which began the first year of life. A Kahn serological test was negative. Four months' treatment with bismuth salicylate had most of the lesions involuting. At the time of this presentation, the only activity remaining is at the left outer canthus of the eye.

CASE 2. This Negro boy, aged 12, had received no treatment though facial involvement had been present for six years. A Kahn serological test was negative.

Because of the rarity of lupus erythematosus in full-blooded Negro boys, this clinical report should be interesting; particularly so because of the emphasis which has been placed on undue sun exposure producing the disfiguring disease. Other than apparently diseased tonsils, both of these North Florida-born pure Africans are in good health. As far as could be ascertained neither one has had any disabling childhood sickness.



CASE 1

Presented before the Medical Staff Meeting of the Duval County Hospital, Jacksonville, February 21, 1939.

1111 Greenleaf Bldg.



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## SCHOOL HEALTH PROGRAM

A two-weeks' conference beginning August 14, 1939, was held in Gainesville at the University of Florida in the interest of child health as concerns the school child. The idea of this meeting originated in the State Department of Education, Tallahassee, and the Department of Education of the University of Florida. In attendance at this meeting were the representatives from most of the outstanding organizations in Florida who are interested in the maintenance of health in the school child. Dr. Luther W. Holloway of Jacksonville represented the Florida Medical Association by appointment of Dr. Leigh F. Robinson, president.

An unusual opportunity now exists for real, constructive work for the betterment of the health of the school child. For many years those interested in children have sought by various means to establish a liaison between the school authorities and organized medicine but, up to the present time, no actual progress has been made. The success of this movement depends on the full cooperation of the educational authorities, the Public Health Service and Organized Medicine. The State Medical Association stands ready to do its part in

molding a program to be carried out through educational institutions and authorities, insofar as that program relates to questions of a medical nature. Medical knowledge is a requisite in formulating plans in the interest of the health of the school child. To utilize properly the reservoir of medical knowledge in Florida the educational authorities should contact the officers of our State and County Medical Societies.

In the meetings of the members of the medical profession who devote themselves to the care of children, many times disappointment has been expressed that something could not be done along this line. Florida will be one of the first states to have the opportunity to benefit in this work. The actual realization of such benefits will, of course, be slow. This is well, because a solid foundation will then be established upon which the work will progress.

## NEW AND NONOFFICIAL REMEDIES

Each year a revised list of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association as of January first is published in book form under the title of "New and Non-official Remedies." The book contains the descriptions of acceptable proprietary substances and their preparations, proprietary mixtures if they have originality or other important qualities, important non-proprietary non-official articles, simple pharmaceutical preparations, and other articles which require retention in the book.

A list of articles and brands accepted by the Council, but not described, is included in the book to cover simple preparations or mixtures of official articles (U. S. P. or N. F.) marketed under descriptive, non-proprietary names for which only established claims are made. Diagnostic reagents which are not used in or on the human body, and protein diagnostic preparations are not included in New and Nonofficial Remedies unless the determination of the status of these products by the Council has been requested by the distributor. If such products are found to be marketed in accordance with the Council's rules, they may be included in the list of undescribed, but acceptable articles.

A supplement to the annual volume of New and Nonofficial Remedies is published twice

a year to bring up to date such current revisions and additions as have been necessary since its last publication. Every product included in the book is subject to the official rules of the Council. The comments to rules are changed occasionally by way of clarifying interpretation to insure fair consideration of all submitted preparations as new standards are recognized. Such constant and critical consideration of its contents provides the physician with a valuable reference list of acceptable new preparations on which to base his selection for use in treatment according to the established current practices of the profession.

New and Nonofficial Remedies for 1939 omits many articles which appeared in the publication for 1938. A few of these have been omitted by action of the Council because they conflict with the rules that govern the recognition of articles or because their distributors did not present convincing evidence to demonstrate their continued eligibility. Among these are: Biliposol, Serobacterins and Suppositories Salyrgan. A considerable number of others have been omitted as being off the market.

The 1939 New and Nonofficial Remedies, of course, contains the revisions which appeared in the supplements for the 1938 edition, and continues the plan of grouping together articles having similar composition or action under a general discussion. These discussions have undergone considerable revision in the 1939 edition. Further revision of statements regarding the actions, uses, dosage, composition, purity, identity, strength or physical properties of many of the articles has also been necessary in some cases. Noteworthy revisions are: Anesthetics, Local; Bismuth Compounds, Organs of Animals; Vitamins and Vitamin Preparations and Liver and Stomach Preparations.

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#### ANNUAL REPRINT OF THE REPORTS OF THE COUNCIL ON PHARMACY AND CHEMISTRY

This volume as usual contains noteworthy examples of the various kinds of reports made by the Council on Pharmacy and Chemistry: (1) preliminary reports; (2) supplemental reports on therapeutic or pharmacologic problems; (3) reports on the rejection of

preparations offered for the Council's consideration.

Among the preliminary reports in this volume that on Sulfapyridine, which carries a special article by Dr. Perrin H. Long, a Council member who has been much concerned with the work on this drug, is perhaps of greatest interest. After the Food and Drug Administration had released the drug for the use of physicians early in 1939, the Council accepted various brands for inclusion in N. N. R. and in connection with the published descriptions issued another status report (J. A. M. A. **112**: 1830, May 6, 1939), based on a questionnaire sent to men who had been prominent in the experimental use of the drug. This report, no doubt, will appear in the next volume of reprinted Council reports. Other preliminary reports are the following: Allantoin, a preparation of glyoxyldiureid proposed to supersede the use of surgical maggots; and Sulfapyridine, published shortly before the Council acceptance of this new chemotherapeutic drug.

Among the supplemental (or status) reports are those on Colloidal Sulfur in the Treatment of Chronic Arthritis, showing that much confirmatory evidence is needed to establish the value of this therapy; on Ergonovine, a careful study of the relation of this newly discovered principle to ergot therapy in general; and on Picrotoxin in Poisoning by the Barbiturates, showing the promise and the present limitations of this antidotal therapy.

Among the reports of rejection the following are noteworthy: Collodaurum, a "colloidal gold" preparation, promoted with unwarranted, exaggerated and misleading claims for its use in the treatment of cancer; Dermo-G, stated to be a mixture of Spermaceti, White Wax, Oil of Sweet Almonds, Sodium Borate, Precipitated Sulphur and Water, an unscientific and superfluous mixture marketed under a therapeutically suggestive name with exaggerated, unwarranted claims; Fru-T-Lax, a needlessly complex and unscientific mixture advertised to the public under a misleading and inadequately descriptive name with claims which are unwarranted; and Hyposols Sulisocol, claimed to be "Sulphur Colloid" in 2 cc. of "Autoisotonized Solution," exploited for use in arthritis with inadequate evidence of its therapeutic value.



## SWIMMING EXPOSES MAN TO RISKS OF UNNATURAL ENVIRONMENT

Man's fundamental lack of adaptation to an aquatic environment is just as important a factor as bacterial contamination in causing infections among swimmers. H. Marshall Taylor, M. D., Jacksonville, Fla., asserts in *The Journal of the American Medical Association* for Sept. 2. He points out:

Man is essentially a terrestrial animal. When out of his normal sphere, unless he takes cognizance of the limitations nature has placed on him and heeds the fundamental laws that regulate his being, he subjects himself to the likelihood of contracting the infections that frequently beset the swimmer.

Dr. Taylor's studies lead him to conclude that swimmers contract infections of the ear or sinuses even in pools in which the water is relatively pure. Animals whose natural habitat is water are able to withstand higher concentrations of bacteria because they are anatomically and physiologically adapted to do so. He explains:

In every species whose normal habitat is water, some provision for excluding water from contact with the respiratory mucous membrane is found. The most consistent modification of aquatic mammals for life in the water is the ability to close the external nostrils. This is not the case in man.

Man nevertheless has one natural means of protecting the mucous membrane of the nasal passages when swimming. That protection is the proper method of breathing. By exhaling through the nose while the head is submerged and inhaling through the mouth while the head is above water, the swimmer tends to maintain a positive air pressure in the nasal cavities and thereby protects the sinuses and the canal between the ear drum and the pharynx from water.

In the new strokes that require partial or complete submersion of the face and head, this method of breathing is highly important. The swimmer should take a deep inhalation through the mouth just before diving and then exhale slowly through the nose while under the water.

The rush of water into the nasal cavities incident to diving feet foremost may readily cause acute infections of the sinuses, the middle ear and the mastoid in swimmers of all ages.

Another consistent modification that all aquatic animals have for life in the water is the ability to close the ear in order to prevent water from coming in contact with the ear drum. The lack of this provision in man adds another piece of evidence to the fact that he is a terrestrial animal.

In man there is a conspicuous lack of a compensating mechanism for the maintenance of a normal temperature in any medium colder than his normal surroundings. Man's loss of body heat during submersion for a period of twenty minutes at a temperature of 70 F. may be five times the normal rate. Water takes away heat from the body twenty-seven times faster than air.

Summarizing an experiment which he made on lowered resistance from chilling in relation to infections of the ear and sinuses following swimming, Dr. Taylor says:

The temperatures of 250 children under 13 years of age were recorded both before and after they had been swimming for forty-five minutes in an indoor pool with the temperature of the water at 73 F. In only thirty, or 12 per cent, was a normal temperature maintained, and in all the remaining 220 there was a reduction of temperature; in some the temperature fell as low as 95 F.

The child or adult, particularly when frequenting the indoor swimming pool where the body is not exposed to the warm rays of the sun, should be constantly active instead of following the common practice of sitting around on a cold tile floor in a cold wet bathing suit. This popular custom is as conducive to catching cold as wrapping oneself in a wet blanket and sitting on the concrete floor of a basement would be. The bather who is inactive on a windy beach, where there is a rapid loss of body heat from evaporation, invites the same risk.

## MEDICAL LICENSES GRANTED

Dr. W. M. Rowlett, Secretary of the State Board of Medical Examiners, announces that 143 applicants were successful in passing the State Board examination held June 19-20. There were 24 failures. Several nationally known physicians were among those licensed, one of the best known being Dr. Temple S. Fay of Philadelphia. The names and addresses of those who passed the examination and were licensed are as follows:

Able, LeGrand Guerry	Greenville, S. C.
Albert, Irwin Charles	Cincinnati, O.
Andrews, Edson James	Manitowoc, Wis.
Atkinson, Samuel Carter	Waverly, Ga.
Baeseman, Reuben Winfield	Asbury Park, N. J.
Belle, Martin Samuel	Atlanta, Ga.
Bippus, William Edward	Monticello
Blackman, Raymond Scrivener	Jacksonville
Blalock, Tully Talbot	Jacksonville
Blessing, Robert	Evanston, Ill.
Bloomfield, Sylvan	Brooklyn, N. Y.
Blum, Leo J., Jr.	Macon, Ga.
Brenner, Edward Christopher	Ft. Lauderdale
Butt, Martin Edward	Orlando
Butcher, John Mack	Washington, D. C.
Butler, Fred Arthur	Havana
Butt, Arthur Jordan, Jr.	Pensacola
Byrd, Edwin Samuel	Atlanta, Ga.
Chapman, Jules Benjamin	Jacksonville
Cleveland, Robert Henry	Jacksonville
Cline, Wade Martin	Lakeland
Cohen, Rebecca	St. Petersburg
Cole, Herschel George	Hammond, Ind.
Cone, Adolph	Jacksonville Beach
Costantino, Eugene Francis	Tampa
Corum, Lewis Townsley	Corbin, Ky.
Cueto, Andrew Alexander	Cincinnati, O.
Daffin, Charles Hall	Jacksonville
Davey, Walter Fletcher	Philadelphia, Pa.
Davis, Edwin Brown, Jr.	Byronville, Ga.
Dieterich, Frederick Henry	Miami Beach
Dobbins, Burns Alan, Jr.	Jacksonville
Dunham, Kenneth	St. Augustine
Eberhart, Charles Abel	Atlanta, Ga.
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Elliott, Cecil Benjamin	Gainesville, Ga.
Farber, Herman	Richmond, Va.



Farrer, Frederick Eugene	St. Petersburg	Stoddard, Guy Russell	Coral Gables
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Foster, L. Paul	Orlando	Tench, William Ryan	Clearwater
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Gifford, John Pearl	Jacksonville	Trice, William Waller, Jr.	Tampa
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McGough, James Wylie	Cleveland, O.		
McKinnon, Daniel Angus, Jr.	Marianna		
Maiden, Sara Howarth	DeLand		
Martin, Felix Breaux	Nashville, Tenn.		
Mauldin, John Tyler	Atlanta, Ga.		
Meadow, Edward	Miami		
Meyer, Francis Poynter, Jr.	St. Petersburg		
Meyers, Max Irving	Columbia, Pa.		
Mickley, John Hoke	Tabor City, N. C.		
Miller, Edward Simpson	Jacksonville		
Mills, Richard Ambrose	Hollywood		
Mims, James Lloyd	Marion, S. C.		
Mitchell, George Alfred	St. Louis, Mo.		
Monroe, Lance Truman	Mountain View, Ark.		
Moore, John Phillips	Ocala		
Murray, Nelson Arnold	Jacksonville		
Needles, Robert Johnson	Atlantic, Iowa		
Noel, William Walker	Detroit, Mich.		
Norris, Hardgrove Spofford	St. Augustine		
Parish, Frank Matthews	DeLand		
Parr, Luther Hermann	Miami		
Patterson, Vivian Pierce	Ft. Meade		
Pernoud, Flavius Gentry, Jr.	St. Louis, Mo.		
Pinson, Harry Dupree	Ochlochnee, Ga.		
Provinsky, Leo Bernard	Jacksonville		
Purcell, Thomas Riffel	Umatilla		
Quattlebaum, Frank Walter	Pavo, Ga.		
Rawlins, Albert George	Jacksonville		
Rich, Maurice	Atlanta, Ga.		
Saltz, Nathan Jacob	Jacksonville		
Sawyer, James Latimer	Folkston, Ga.		
Schlesinger, William Lee	Cleveland, O.		
Schwarz, Milton Jandon	Miami Beach		
Shalloway, Charles Leon	Atlanta, Ga.		
Simmons, Stanley Tenant	Louisville, Ky.		
Smith, Harry Bryant	Marianna		
Smoak, Philip Laurens	Tampa		
Smoot, Richard Henry	Decatur, Ga.		
Stankus, Donald George	DeKalb, Ill.		
Stetcher, Joseph Lewis	Montverde		
Stern, Henry Maximilian	DeLand		
Stillman, Sidney	Jacksonville		

## BIRTHS

Dr. and Mrs. Carlos P. Lamar of Miami announce the birth of a daughter on August 21 at the Jackson Memorial Hospital.

\* \* \*

Dr. and Mrs. Earl H. Roberts of Jacksonville Beach announce the birth of a son, Eugene Jefferson, on August 12 at St. Vincent's Hospital.

## STATE NEWS ITEMS

At the June meeting of the State Board of Medical Examiners the following officers were elected: President, Dr. S. G. Hollingsworth, Bradenton; Vice-President, Dr. B. A. Chapman, Jacksonville; Secretary-Treasurer, Dr. W. M. Rowlett, Tampa. The other board members are: Dr. H. D. Van Schaick, Jacksonville; Dr. J. C. Davis, Quincy; Dr. J. E. Crump, Winter Haven; Dr. H. A. Day, Orlando; Dr. Thomas W. Hutson, Miami; Dr. C. E. Tumlin, Miami; and Dr. Carl A. Williams, St. Petersburg.

\* \* \*

Dr. M. B. Marks of Miami Beach has returned from Harvard University and the Massachusetts General Hospital where he took an intensive course in allergy with Dr. Francis Rackemann.

\* \* \*

Dr. George M. Green of Daytona Beach moved recently into his new modernistic building on the north side of Broadway near the river. Reports indicate that this new medical center is complete and up-to-date.



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Dr. T. F. Hahn and Dr. J. E. Taylor of DeLand were appointed recently on Volusia County's permanent sanity committee, by County Judge J. E. Peacock, in accordance with a new act of the legislature. There is one layman on the committee.

\* \* \*

Dr. L. L. Whiddon of Ft. Pierce took postgraduate work in obstetrics at Johns Hopkins University in July.

\* \* \*

Drs. W. M. Rowlett and H. Mason Smith of Tampa left the middle of August for a five weeks' vacation in Alaska. Mrs. Smith, Mrs. Rowlett and H. Mason Smith, Jr., accompanied them on the trip.

\* \* \*

Dr. Lloyd J. Netto and family of West Palm Beach spent some time in the North the latter part of August, Doctor Netto visiting a number of clinics. Miss Betsy Netto was recently selected Lady of the Bracelet at Camp Nakawana, Mayland, Tenn.

\* \* \*

Dr. and Mrs. Ralph Gowdy, their son, Robert, and daughter, Margaret, of Miami Beach have returned from the mountains of North Carolina. They visited Davidson College near Charlotte where Robert will attend school this year.

\* \* \*

Dr. G. Thomsen-von Colditz of Cocoa has returned from a 5,000-mile motor trip, during which he visited Asheville, New York City, Boston, Niagara Falls, Chicago and Atlanta.

\* \* \*

Dr. F. Gordon King of Jacksonville recently announced the limitation of his practice to the field of anesthesiology.

\* \* \*

Dr. Paul K. Jenkins and family have returned from a two months' vacation which began with the Golden Gate Exposition in San Francisco and ended with the New York World's Fair. They stopped at many places of interest in Colorado and in the Black Hills of South Dakota.

---

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## WILBUR ASHLEY McPHAUL

Dr. Wilbur A. McPhaul of Jacksonville, State Health Officer, died August 1, following an illness of several months.

A native of Robeson County, North Carolina, Doctor McPhaul attended the University of the South at Sewanee, Tenn., and was a graduate of the University of Nashville, now a part of the University of Tenn., where he received his medical degree in 1905. He took postgraduate work in tropical medicine at Tulane University.

Doctor McPhaul was well known in public health circles throughout the South, having held positions not only in his native State and Florida, but also in Alabama. The first county health unit law in the United States was passed in 1911 through the efforts of Doctor McPhaul while he was serving as a member of the House of Representatives of the North Carolina Legislature. He maintained his interest in full-time county health units and fourteen of Florida's sixteen county units were established during his regime as State Health Officer.

Doctor McPhaul was appointed State Health Officer in 1936 by Governor Sholtz, and was reappointed to this position by Governor Cone.

Surviving are his widow, Clara Grantham McPhaul, a daughter, three sons, and two grandchildren.

The Duval County Medical Society, of which Doctor McPhaul was a member, recently passed the following resolutions:

WHEREAS, Dr. Wilbur A. McPhaul, health officer of the State of Florida, died at Jacksonville on August 1, 1939, and

WHEREAS, Doctor McPhaul was esteemed by all who knew him and particularly by his associates of the medical society of Duval County and by public health officials throughout the South, and

WHEREAS, Doctor McPhaul distinguished himself because of his untiring efforts to improve medical facilities for the public, especially the underprivileged, in furtherance of which he authored and was responsible for enacting the first local health unit law in the United States, and

WHEREAS, Doctor McPhaul's inspiration, leadership and willingness to cooperate did much to cement the spirit of friendliness between private physicians and public health officials, and

WHEREAS, Doctor McPhaul devoted his entire career to the welfare of humanity and created an enviable record of achievement for the benefit of the citizens of the State of Florida, therefore

BE IT RESOLVED that the Duval County Medical Society hereby expresses its sincere regret over the irreparable loss to the State Board of Health, and





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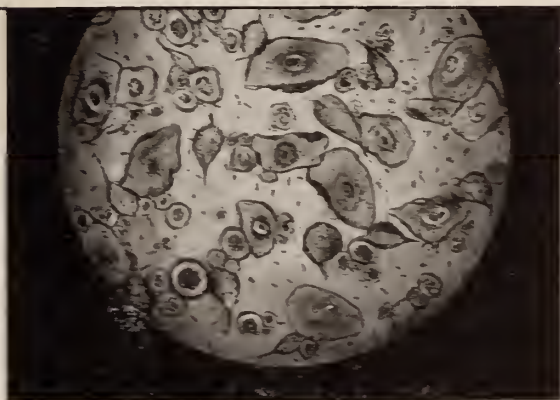
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BE IT FURTHER RESOLVED that this resolution be placed upon the minutes of the Duval County Medical Society and that copies thereof be sent to Mrs. Clara Grantham McPhaul, his widow, and other members of his family, and to the staff of the State Board of Health who served under him, and to the Florida Public Health Association with which he worked so closely.

### JOHN THOMAS DENTON

Dr. John T. Denton, a practicing physician in Sanford for more than three decades, died in a Greenville, S. C., hospital, August 3. Doctor Denton became suddenly ill at Saluda, N. C., on July 29 while attending the Southern Pediatric Seminar.

Doctor Denton was born in Mississippi on February 23, 1879, and has practiced medicine in Sanford since 1905, after his graduation from the University of the South at Memphis, Tenn. During the past few years he specialized in pediatrics and for several years attended regularly the clinics held at Saluda.

Active in medical circles, Doctor Denton was a past president of the Seminole County Medical Society, a member of the Florida Medical Association and the American Medical Association. During the World War he served as chief examiner for the draft board in Seminole County. He was also a Mason and an active member of the First Baptist Church, serving as deacon emeritus for the church at the time of his death.

Doctor Denton is survived by his widow and one son, Robert H. Denton of Winter Haven.

### GASTON DAY

Dr. Gaston Day of Jacksonville died suddenly at his home on August 5.

A native of Montgomery, Ala., where he was born in 1882, the son of Henry E. and Ellen L. Day, he attended the University of Florida and obtained his medical degree from Johns Hopkins University. Doctor Day came to Jacksonville, upon the completion of his medical training, to practice his profession. He served as a major in the Medical Corps during the World War.

Doctor Day is survived by his widow, Juanita Lord Day of Jacksonville.

The following commemorative resolutions were recently passed by the Duval County Medical Society, of which Doctor Day was a member:

Late in the evening of the fifth of August, 1939, the entire membership of the Duval County Medical Society suffered the great loss of one of its most valued friends, members, and gracious co-workers in the advancement and practice of Medicine and Surgery.

The absence of Doctor Gaston Day from our midst causes a keen loss of wise counsel and expert assistance to all of us who have benefited by his abundant co-operation for the benefit of mankind, to which he contributed to the limit of his splendid abilities.

Doctor Gaston Day came to this State when he was but a child, attended the local schools, and received the Bachelor of Science degree from the University of Florida in 1906, and his Florida State Certificate in 1908.

THEREFORE BE IT RESOLVED, as evidenced by the silent standing of the members of the Duval County Medical Society in the meeting of August eighth, 1939, that the members of this Society express their great respect for the beautiful character and fine achievements of Doctor Gaston Day, and

BE IT FURTHER RESOLVED that this resolution be placed upon the minutes of the Duval County Medical Society, and that copy thereof be sent to Mrs. Juanita Day, his widow, together with our deepest sympathies.

### COMPONENT COUNTY SOCIETIES

#### BREVARD COUNTY MEDICAL SOCIETY

The regular meeting of the Brevard County Medical Society was held in the office of Dr. I. M. Hay at Melbourne on August 9. Dr. L. J. Hanchett of Jacksonville, acting director of the Division of Venereal Disease Control of the State Board of Health, showed a motion picture on syphilis and gave a short talk in connection with the film, as a feature of the scientific program.

\* \* \*

#### PINELLAS COUNTY MEDICAL SOCIETY

Dr. Neil E. Funk was principal speaker at the regular meeting of the Pinellas County Medical Society held August 4 at the Chat-terbox. His subject was "Rambling Among the Hospitals."

At the Academy meeting of the Society held on the evening of August 18 at the Power and Light Building, St. Petersburg, Dr. H. M. Rogers presented "Acute Coronary Occlusion," and Dr. C. S. Franckle discussed "Gastric Ulcer."

#### MEDICAL DISTRICT MEETINGS

Lakeland (D) . . . . Sept. 28

West Palm Beach (F) Oct. 12

Ocala (B) . . . . . Oct. 26

Sanford (E) . . . . . Nov. 9







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## ABSTRACT DEPARTMENT

*Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.*

**Air Transport Flying from the Medical Standpoint, Medical Dept. Eastern Air Lines, Inc., by GREENE, RALPH, Coral Gables, *J. Aviation Med.* 10: 12-30 (Mar.), 1939.**

Greene, in a detailed and extremely interesting paper, outlines the exhaustive minutiae incident to the proper operation of an Air Line Medical Department.

The subject is thoroughly covered from the initial examination of the pilot, requiring an entire day and including physical and special sense examinations, along with personality and psychological tests, on down to the question of investment of his savings and his ability to get along with his wife.

Those interested in the subject of aviation medicine will derive a great deal of pleasure from a perusal of the original article.

**The Employment of Multiply Infected Anopheles Quadrimaculatus to Effect Inoculation with Plasmodium Vivax and P. Falciparum, BOYD, MARK F.; KITCHEN, S. F.; and KUPPER, W. H., Tallahassee, *Am. J. Trop. Med.* 17: 849-853 (Nov.), 1937.**

The authors applied *A. quadrimaculatus* successively to patients harboring *P. vivax* and *P. falciparum* in such a way that one group would mature *vivax* first, another *falciparum* first and the third would mature both simultaneously.

These lots were in turn applied to patients in such a way that, taking into consideration the maturation cycle of the particular plasmodium, facts could be obtained as to their individual infectivity. On the whole the results were in agreement with the authors' expectations and they conclude:

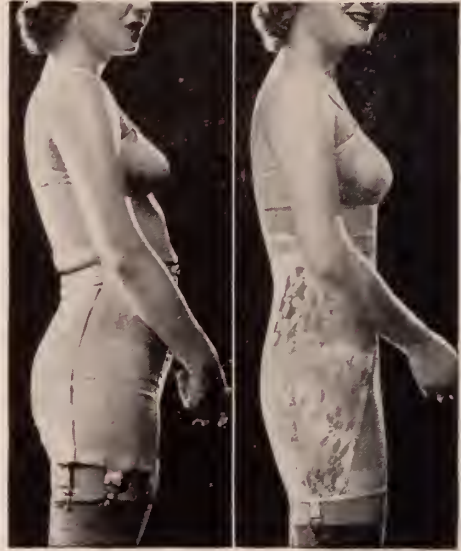
(a) The sporogonous cycles of both are completed within the periods to be expected from the temperature of incubation.

(b) A head start by either species does not adversely affect the other.

(c) Mosquitoes multiply-infected with two species of malaria parasites under a variety of conditions can successfully transmit both.

(d) Transmission of a single parasite by multiply-infected mosquitoes is attributable either to the earlier maturation of the cysts of one species, or to the earlier exhaustion or normal degeneration of the sporozoites of one species.

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## BOOKS RECEIVED

*Acknowledgment of books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review, as expedient.*

**CANCER HANDBOOK.** Edited by ERIC LILJENCRANTZ, M. D., Chief of Tumor Clinic, Stanford University School of Medicine; consultant in Neoplastic Disease, U. S. Naval Hospital, Mare Island, and U. S. Marine Hospital, San Francisco. The methods advocated by this book are based on present practice at the Stanford University Tumor Clinics. The volume is designed "especially for a brief graduate course, elementary enough for any medical practitioner, yet complete enough to prepare the practitioner for adequate handling of patients as to cancer, through the stages of suspicion, diagnosis, consultation and treatment. It is well fitted to serve as a desk summary." Cloth. Price, \$3.00. Pp. 114, with 50 illustrations. California: Stanford University Press.

**THE ROCKEFELLER FOUNDATION: ANNUAL REPORT 1938.** By THE ROCKEFELLER FOUNDATION, RAYMOND B. FOSDICK, president. A general review of the work of the Foundation for the period January 1, 1938, to December 31, 1938, with detailed reports of the Secretary and the Treasurer, the Director of the International Health Division, the Directors of the Medical Sciences, the Natural Sciences, the Social Sciences, and the Humanities, and the Vice-President in charge of the program in China. Paper, Pp. 515, with 27 illustrations. New York: The Rockefeller Foundation.

**THE SERODIAGNOSIS OF SYPHILIS: SUPPLEMENT NO. 9 TO VENEREAL DISEASE INFORMATION.** By UNITED STATES PUBLIC HEALTH SERVICE. In two parts: Part I contains the proceedings of the Assembly of Laboratory Directors and Serologists held under the auspices of the Committee on Evaluation of Serodiagnostics Tests for Syphilis and the United States Public Health Service, October 21-22, 1938, at Hot Springs National Park, Arkansas. Part 2 gives the revised technics of the Eagle, Hinton, Kahn, Kline, and Kolmer tests. Paper, Pp. 224; illustrated. For sale by the Superintendent of Documents, Washington, D. C. Price 30c. United States Government Printing Office.

**CONTROL OF THE VENEREAL DISEASES IN THE UNITED STATES: PRESENT AND FUTURE PLANS. SUPPLEMENT NO. 10 TO VENEREAL DISEASE INFORMATION.** By UNITED STATES PUBLIC HEALTH SERVICE. Contains foreword by Thomas Parran, M.D., Surgeon General, U. S. P. H. S., and chapters on "Regulations Governing Allotments and Payments to the States for Venereal Disease Control Activities for the Fiscal Year 1940" and "Recommendations for a Venereal Disease Control Program in State and Local Health Departments." Paper, Pp. 25. For sale by the Superintendent of Documents, Washington, D. S. Price 10c. U. S. Government Printing Office.

**NEW AND NON-OFFICIAL REMEDIES, 1939,** containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on Jan. 1, 1939. Cloth. Price, postpaid, \$1.50. Pp. 617. Chicago: American Medical Association, 1939.

**ANNUAL REPRINT OF THE REPORTS OF THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION FOR 1938.** Cloth. Price, \$1.00. Pp. 120. Chicago: American Medical Association, 1939.



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## ADVERTISERS' NOTES

### THE AMBLYOPIA READER

The "Amblyopia Reader," written by Dr. Margaret Dobson and published in England, is considered a successful means of stimulating vision in the amblyopic eye. It is also widely used to detect hyperphoria, and in diagnosing defective vision of one eye in cases of refractive errors and congenital blindness. It comes complete with equipment and directions as to technique.

Copies of the Reader can be secured from the American Optical Company, Southbridge, Mass.

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"Metycaine" belongs to the group of substituted piperidino-alkyl benzoates prepared by McElvain and is commercially available from Eli Lilly and Company.

### SQUIBB INSTITUTE FOR MEDICAL RESEARCH

The Division of Organic Chemistry is carrying on research concerning the isolation, concentration, and chemical structure of vitamin K. Another study in progress under direction of Dr. Fernholz in collaboration with Doctor Archie Black deals with the isolation and purification of vitamin B<sub>6</sub>, lack of which is related to the occurrence of the chronic disease pellagra. Dr. Fernholz is also collaborating with Dr. Ansbacher on the filtrate factor of vitamin B complex. The Division's program also includes a theoretical investigation in the field of steroids.

The Division of Pharmacology, under Dr. van Dyke, is attempting to isolate and purify some of the hormones of the pituitary body. Dr. van Dyke describes the pituitary gland as the most interesting of the glands of internal secretions because it rules or coordinates the action of all other glands. For the present, the research concerns chiefly the anterior pituitary hormones, which maintain the ovaries and testes.

Another investigation proceeding in the Division of Pharmacology deals with new chemo-therapeutic compounds. This work is being done in collaboration with the Medicinal Chemistry Laboratory and the Division of Bacteriology and Virus Diseases. The Division of Pharmacology will also foster research in the field of synthetic medicinal remedies for the treatment of cardiovascular diseases.

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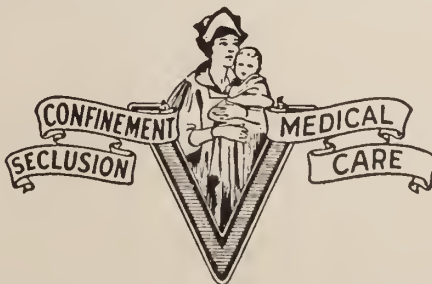
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## COMPONENT SOCIETIES BY DISTRICTS — FLORIDA MEDICAL ASSOCIATION

Districts	COUNTY SOCIETIES	PRESIDENT	SECRETARY	MEETING DATE	COUNCILOR and Counties Not Included in First Column	Members	
						Total	Paid
Northwest District (A) Marianna July 20, 1939	Bay	Donald S. Fraser, M.D. Panama City	William C. Roberts, M.D. Panama City		A-1-'40 Carol C. Webb, M.D. Pensacola	12	100%
	Escambia	L. C. Fisher, Jr., M.D. 816 N. Palafox St. Pensacola	J. M. Hoffman, M.D. 1221 E. DeSoto St. Pensacola	2nd Tuesday 8:00 P. M.		44	38
	Walton-Okaloosa	A. G. Williams, M.D. Lakewood	R. E. Spires, M.D. DePuniak Springs	3rd Thursday 8:00 P. M.		6	100%
	Washington-Holmes	W. D. Ramsey, M.D. Noma	L. H. Paul, M.D. Bonifay		Santa Rosa	8	7
	Franklin-Gulf	Chapman Dykes, M.D. Carrabelle	A. L. Ward, M.D. Port St. Joe	3rd Thursday	A-2-'41 B. A. Wilkinson, M.D. Tallahassee	6	100%
	Jackson	C. J. Price, M.D. Alford	R. N. Joyner, M.D. Marianna	2nd Tuesday 7:30 P. M.		13	12
	Leon-Gadsden-Liberty-Wakulla-Jefferson	W. W. Massey, M.D. 204 N. Madison St. Quincy	B. A. Wilkinson, M.D. Telephone Bldg. Tallahassee	Quarterly 3:00 P. M.	Calhoun	38	33
North Central District (B) Ocala October 26, 1939	Columbia	W. M. Ives, M.D. 132 N. Marion St. Lake City	Harry S. Howell, M.D. Blanche Hotel Annex Lake City	1st Monday 7:30 P. M.	B-3-'41 W. S. Nichols, M.D. Lake City	21	16
	Madison	E. Long, M.D. Madison	A. F. Harrison, M.D. Madison			3	2
	Taylor	Geo. H. Warren, M.D. Perry	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P. M.	Baker-Dixie-Hamilton-Lafayette-Suwannee	8	6
	Alachua	J. E. Maines, Jr., M.D. 433 E. Main St. N. Gainesville	J. Maxey Dell, Jr., M.D. 333 W. Main St. S. Gainesville	2nd Friday 7:30 P. M.	B-4-'40 James L. Strange, M.D. McIntosh	29	24
	Marion	Carl S. Lytle, M.D. Dunnellon	R. C. Cumming, M.D. Commercial Bank Bldg. Ocala	3rd Thursday 12:30 P. M.		23	100%
	Pasco-Hernando-Citrus	Claude L. Carter, M.D. Inverness	G. R. Creekmore, M.D. Brooksville	2nd Thursday 7:00 P. M.		15	100%
	Sumter	Clyde L. Carter, M.D. Wildwood		2nd Tuesday	Bradford-Gilchrist-Levy-Union	3	2
N. E. District (C) Palatka September 14, 1939	Duval	Thomas E. Buckman, M.D. 1022 Park St. Jacksonville	Lauren M. Sompayrac, M.D. 459 St. James Bldg. Jacksonville	1st Tuesday 8:15 P. M.	C-5-'41 R. B. McIver, M.D. Jacksonville	174	172
	St. Johns	R. D. Harris, M.D. St. Augustine	G. Walter Potter, M.D. East Coast Hospital St. Augustine	3rd Tuesday 8:30 P. M.	Clay-Nassau	10	100%
	Putnam	Edward W. Ford, M.D. Crescent City	C. M. Knight, M.D. Palatka	2nd Tuesday in Feb., April, June, Aug., Oct., Dec. 7:00 P. M.	C-6-'40 George M. Green, M.D. Daytona Beach	11	10
	Volusia	Maximilian Stern, M.D. Box 5098 Daytona Beach	R. L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P. M.	Flagler	41	40
Southwest District (D) Lakeland September 28, 1939	Hillsborough	J. W. Alsobrook, M.D. 120 N. Collins St. Plant City	James S. Grable, M. D. 811 Citizens Bank Bldg. Tampa	1st Tuesday 8:00 P. M.	D-7-'41 W. C. McConnell, M.D. St. Petersburg	110	94
	Manatee	S. G. Hollingsworth, M.D. 451 12th St. Bradenton	M. M. Harrison, M.D. Professional Bldg. Bradenton	3rd Tuesday 7:00 P. M.		14	100%
	Pinellas	E. C. MacCordy, M.D. 366 First Federal Bldg. St. Petersburg	W. C. McConnell, M.D. 1001 First Federal Bldg. St. Petersburg	1st and 3rd Fridays 6:30 P. M.		93	100%
	Sarasota	T. W. Taylor, M.D. Professional Bldg. Sarasota	Stanley T. Martin, M.D. Sarasota	2nd Tuesday 8:30 P. M.		17	14
	DeSoto-Hardee-Highlands-Charlotte-Glades	Ben D. Spears, M.D. Wauchula	Howard V. Weems, M.D. 22 Oak St. Sebring	2nd Tuesday 8:00 P. M.	D-8-40 Herman Watson, M.D. Lakeland	20	100%
	Lee	C. Gordon Merrick, M.D. 26 Leon Bldg. Fort Myers	H. L. Allan, M.D. 312 Pythian Bldg. Fort Myers	3rd Friday 7:30 P. M.		14	12
	Polk	John F. Wilson, Jr., M.D. Box 254 Lakeland	J. R. Boulware, Jr., M.D. P. O. Box 367 Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P. M.	Collier-Hendry	62	100%
South Central District (E) Sanford November 9, 1939	Brevard	W. J. Creel, M.D. Eau Gallie	I. K. Hicks, M.D. Melbourne	3rd Tuesday	E-9-'40 W. C. Page, M.D. Cocoa	11	8
	Lake	W. G. DeVane, M.D. Groveland	Oliver Emerson, M.D. Tavares	1st Thursday 12:30 P. M.		18	13
	Orange	C. D. Hoffmann, M.D. 120 E. Robinson St. Orlando	Fred Mathers, M.D. Box 53 Orlando	3rd Wednesday 8:30 P. M.		77	75
	Seminole	Thomas F. McDaniel, M.D. Seminole County Bank Bldg. Sanford	Douglas G. Scott, M.D. 212 N. Park Ave. Sanford	2nd Monday 7:00 P. M.	Osceola	12	100%
	St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D. Box 942 Stuart	Adrian M. Sample, M.D. Ft. Pierce	3rd Thursday 8:00 P. M.	E-10-'41 A. M. Sample, M.D. Ft. Pierce	17	100%
	Broward	R. L. Ellison, M.D. 814 Sweet Bldg. Ft. Lauderdale	Oliver C. Brown, M.D. 915 Sweet Bldg. Ft. Lauderdale	4th Wednesday 8:00 P. M.	F-11-'40 Lloyd J. Netto, M.D. West Palm Beach	34	100%
S. E. District (F) West Palm Beach October 12, 1939	Palm Beach	Gaylord Lewis, M.D. 916 Harvey Bldg. W. Palm Beach	C. Jennings Derrick, M.D. Box 574 W. Palm Beach	4th Monday 8:00 P. M.		58	100%
	Dade	M. Jay Flipse, M.D. 305 Huntington Bldg. Miami	Franz Stewart, M.D. 1105 Huntington Bldg. Miami	1st Tuesday 8:30 P. M.	F-12-'41 Kenneth Phillips, M.D. Miami	295	263
	Monroe	Harry C. Gsley, M.D. 532 Fleming St. Key West	W. R. Warren, M.D. 511 Eaton St. Key West	1st Sunday 9:00 P. M.		4	100%

STATE AND SECTIONAL MEETINGS

SOCIETY	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association.....	Leigh F. Robinson, Ft. Lauderdale	Shaler Richardson, Jacksonville...	Tampa, 1940
Florida Medical Districts:			
A—Northwest .....	Carol C. Webb, Pensacola.....	Stewart Thompson, Jacksonville...	Marianna, July 20, 1939
B—North Central .....	J. L. Strange, McIntosh.....	" " "	Ocala, Oct. 26, 1939
C—Northeast .....	George M. Green, Daytona Beach	" " "	Palatka, Sept. 14, 1939
D—Southwest .....	Herman Watson, Lakeland.....	" " "	Lakeland, Sept. 28, 1939
E—South Central .....	W. C. Page, Cocoa.....	" " "	Sanford, Nov. 9, 1939
F—Southeast .....	Lloyd J. Netto, West Palm Beach	" " "	West Palm Beach, Oct. 12, 1939
Alabama Medical Association.....	M. S. Davie, Dothan.....	D. L. Cannon, Montgomery.....	Birmingham, April 16-18, 1940
Georgia, Medical Assn. of.....	W. H. Myers, Savannah.....	E. D. Shanks, Atlanta.....	Savannah, April 23-26, 1940
Florida—			
State Dental Association.....	R. P. Taylor, Jacksonville.....	E. C. Lunsford, Miami.....	West Palm Beach, Oct. 12-14, 1939
Soc. of Derm. and Syph.....	Elmo D. French, Miami.....	Lauren M. Sompayrac, Jacksonville	Jacksonville, Nov. 1939
East Coast Medical Association.	Frederick J. Waas, Jacksonville..	A. J. Logie, Jacksonville.....	Jacksonville, Nov. 10-11, 1939
State Hospital Association.....	J. H. Therrell, Chattahoochee....	Mr. Fred M. Walker, Jacksonville.	Mississippi, March, 1940
Assn. of Industrial Surgeons.....	C. E. Tumlin, Miami.....	A. M. Bidwell, Tampa.....	Tampa, 1940
Internists' Society.....	Norval M. Marr, St. Petersburg...	Kenneth Phillips, Miami.....	Tampa, 1940
Medical Postgraduate Course...	Turner Z. Cason, Jacksonville....	Chairman	Jacksonville, 1940
Soc. of Ophthal. & Otol.....	S. B. Forbes, Tampa.....	Temporary Chairman.....	Tampa, 1940
State Nurses Association.....	Mrs. Inez Nelson, Orlando.....	Mrs. Phyllis Leonard, St. Augustine	Lakeland, Nov. 6-8, 1939
Pediatric Society.....	Warren W. Quillian, Coral Gables	G. N. Leonard, Miami Beach.....	Tampa, 1940
Pharmaceutical Association.....	Mr. S. F. Harris, Jacksonville....	Mr. A. W. Morrison, Miami.....	Tampa, May, 1940
Public Health Association.....	Mr. S. D. Macready, W. P. Beach	E. M. L'Engle, Jacksonville.....	Jacksonville, 1939
Radiological Society.....	H. B. McEuen, Jacksonville.....	J. N. Moore, Ocala.....	Tampa, 1940
Railway Surgeons' Association...	H. D. Clark, Ft. Pierce.....	W. C. Page, Cocoa.....	Tampa, 1940
Tuberculosis & Health Assn.....	Mr. G. E. Therry, W. Palm Beach...	Mrs. May Pynchon, Jacksonville...	Spring, 1940
Chattahoochee Valley Med. Assn...	M. Y. Dabney, Birmingham.....	Frank K. Boland, Atlanta.....	Albany, Ga., July 9-11, 1940
Gulf Coast Clinical Society.....	J. H. Dodson, Mobile.....	C. C. Rouse, Mobile.....	Mobile, Oct. 26-27, 1939
Internat. Assn. Milk Sanitarians..	Mr. V. M. Ehlers, Austin, Texas..	Mr. C. Sidney Leete, Albany, N. Y.	Jacksonville, Oct. 25-27, 1939
Southeastern Derm. Assn.....	J. R. Allison, Columbia.....	Howard King, Nashville.....	Nashville, Sept. 3, 1939
Southeastern Surgical Congress...	R. L. Sanders, Memphis.....	B. T. Beasley, Atlanta.....	Birmingham, Mar. 11-13, 1940
Southern Medical Association.....	W. E. Vest, Huntington, W. Va.	Mr. C. P. Loran, Birmingham....	Memphis, Nov. 21-24, 1939
Suwannee River Medical Society...	T. H. Bates, Lake City.....	H. S. Howell, Lake City.....	

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# The JOURNAL

of the

## Florida Medical Association, Inc.

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No. 4

Jacksonville, Florida, October, 1939

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American Medical Association, New York, June 10-14, 1940  
Florida Medical Association, Tampa, 1940  
Southern Medical Association, Memphis, November 21-24, 1940

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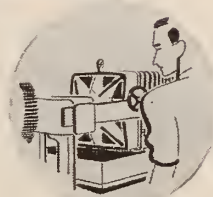
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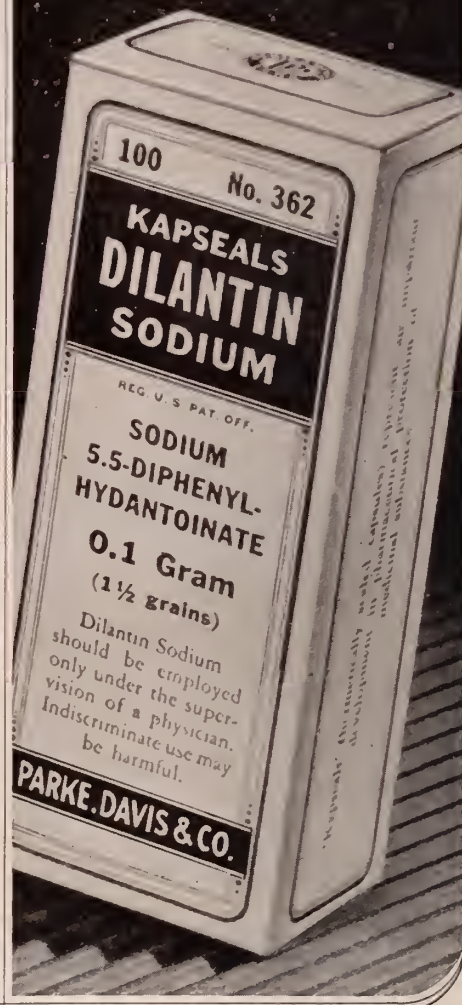


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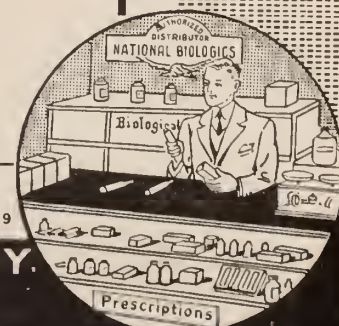
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WEBSTER MERRITT, M. D.  
Jacksonville

This paper is largely the result of a study of 92 patients with hyperthyroidism operated upon at Riverside Hospital in Jacksonville during the last ten years. The analysis is entirely from the medical or internist's point of view.

Hyperthyroidism has been poorly named "exophthalmic goitre." In our experience the majority of the cases show no exophthalmos, and often there is no goitre, not even a palpable diffuse enlargement of the thyroid gland. The term "hyperthyroidism" as used in this paper includes thyrotoxicosis, toxic goitre, Graves' disease or exophthalmic goitre, Plummer's disease or toxic adenomatous goitre, apathetic thyroidism, and masked hyperthyroidism. We feel that while the basal metabolic rate may be relatively low in true hyperthyroidism, it always is elevated above that level of metabolism which the individual had before reaching the hyperthyroid state.

Hyperthyroidism seems to occur in nervous individuals of light frame. Women are affected more often than men.

It is interesting to compare the sex distribution seen in the accompanying table with that in other sections of the country. In Boston and Chicago (patients in the fourth decade), there were four females to one male. In Michigan, an endemic goitre region, the proportion is four to three. You will see that in our series the ratio is about twelve to one. The commonest age group is from 30 to 40, but interestingly enough, the two extremes in our series are 14 and 75, both patients being males.

PLATE I



AGE 75 AGE 14

The oldest and youngest patients in the series of 92 cases of hyperthyroidism operated upon at Riverside Hospital.

TABLE I

Hyperthyroid Patients Operated Upon at Riverside Hospital, 1929-1939

	Number	% of Total
Total	92	100
Sex Distribution:		
Male	7	8
Female	85	92
Age Incidence:		
Under 20	3	3+
20 to 30	23	25
30 to 40	33	36
40 to 50	20	22
50 to 60	9	10
Over 60	4	4+
Age Extremes: 14 and 75, both males.		

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Common symptoms which we see are (1) palpitation, (2) nervous excitability, (3) unstable emotional reactions, such as a tendency to cry on the least provocation, (4) easy fatigability, (5) sensation of heat, (6) excessive perspiration, (7) shaky hands, (8) loss of weight in spite of a good appetite, and (9) indigestion (gastro-intestinal upset). Common signs which we see are: (1) rapid pulse, (2) increased pulse pressure (somewhat increased systolic and somewhat lowered diastolic), (3) hot skin with warm, moist palms, (4) pal-

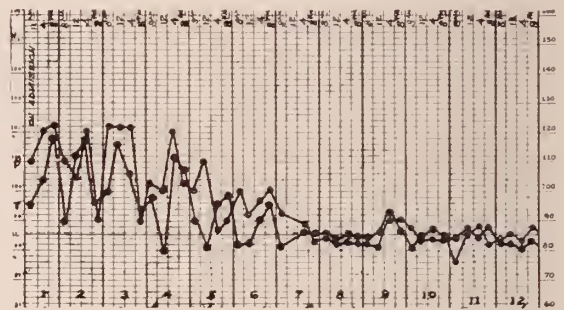
pable thyroid which is smooth, (5) bruit over external carotid artery, (6) therapeutic response iodine, (7) iodine increase in blood, and (8) increased metabolic rate. Uncommon symptoms are: (1) bizarre personality pattern, even dementia, (2) gain in weight, and (3) nausea and vomiting. Uncommon signs are: (1) exophthalmos, (2) palpable thyroid which is nodular, (3) the so-called eye signs (infrequent winking, poor convergence, and lid lag), (4) irregular pulse, and (5) high fever.

In making a diagnosis of hyperthyroidism it is important and often most difficult for the internist to differentiate the disease from neurasthenia and emotional instability. One of the important symptoms in differentiating the neurasthenic from the hyperthyroid is the subjective feeling of warmth and cold. The neurasthenic typically complains of cold hands and feet, whereas the hyperthyroid has hot skin, warm, moist palms, and hot feet; prefers winter to summer. Even here, however, the nervous symptoms and autonomic imbalance may be so outstanding in the hyperthyroid patient that the picture is confused. The basal metabolism, which is of great importance, is often inaccurate on the first and second determinations, because it is so difficult to get the apprehensive, emotionally unstable patient to basal conditions. The therapeutic test with iodine is often of great value in making a diagnosis of a borderline patient of this type. If the patient is not somewhat relieved of his symptoms by iodine administration, he is probably not suffering from hyperthyroidism.

I shall talk about some of the unusual features that have just been outlined, rather than stress those more frequently encountered. About a year ago a 57-year old female came to the hospital, giving her age as 45 and stating that she had been greatly depressed for many years. For several years, she stated, she had been running her finger down her throat to make herself vomit, in order not to gain weight. When questioned about this vomiting, she said she inherited it from her father. Another time, she said, she was visiting a friend who was suffering from the nausea of pregnancy. The patient felt that, since she herself did not have two mouths to feed, she should vomit her food. There were

no hallucinations or supernatural experiences. She had had iodine in the past and had been told that she had hyperthyroidism. On admission her basal metabolism was +25 per cent. While in the hospital she ran a daily temperature up to 102 F. but careful laboratory studies failed to reveal a cause for the fever. I insisted there must be some cause for the fever other than the hyperthyroidism, but the surgeon in charge assured me that he had seen two other cases in which he felt this much fever could be explained on the basis of hyperthyroidism. After receiving intravenous sodium iodide daily for a week, her temperature returned to normal and her basal metabolism was +1 per cent. (*See Plate II*). She was

PLATE II



Return of temperature and pulse to normal during iodine therapy.

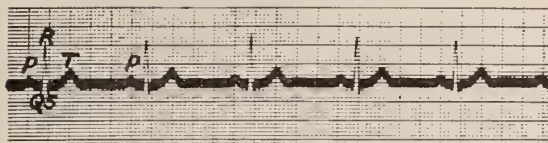
operated on uneventfully, showed well marked improvement, and when seen two and seven months later was well and stable emotionally.

Statistics show that while ten years ago over 3 per cent of all heart disease was due to hyperthyroidism now less than 1 per cent is from this cause. It is thought now that the heart lesion in hyperthyroidism is not inflammatory but due to overwork and perhaps to a depletion of glycogen in the heart muscle.

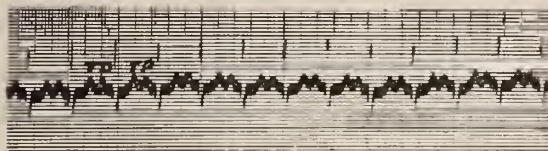
In considering thyrocardiac disturbances undoubtedly the most common is simple tachycardia with regular rhythm. This is illustrated in the electrocardiogram shown in Plate III, which, for purposes of comparison, is accompanied by a normal tracing. In those cases of tachycardia with irregular rhythm we may see almost any type of irregularity, but the most common are auricular fibrillation and premature beats.



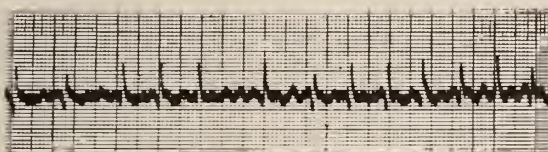
PLATE III



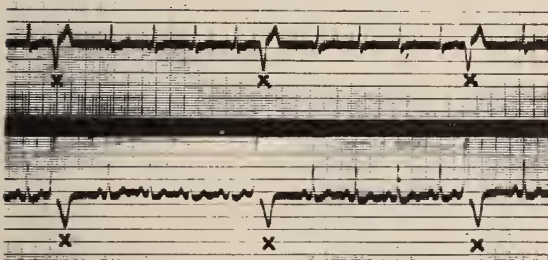
**NORMAL TRACING**



**SIMPLE TACHYCARDIA**



**AURICULAR FIBRILLATION**



**VENTRICULAR PREMATURE BEATS**

Examples of thyrocardiac disturbances compared with a normal tracing.

In those cases of cardiac dysfunction where there is no decompensation, treatment must be directed primarily toward the hyperthyroidism, which is the basic disturbance, rather than toward the heart. In most cases of irregular rhythm there is a reversion to normal rhythm after iodine administration, rest and sedatives, or after operation, although when auricular fibrillation is present it may continue. Dr. Paul White has pointed out a number of times that auricular fibrillation in itself does not indicate any organic disease and that a patient may fibrillate for many years without symptoms and without suffering any apparent harm. As a rule, it is our custom to administer quinidine to those patients who have been fibrillating a relatively short time and who do not show a spontaneous reversion postoperatively. We usually give 3 grains of quinidine sulfate by mouth every four to six hours.

Whether the rhythm is regular or irregular,

the heart may occasionally become decompensated, but this usually occurs in older patients who have had hyperthyroidism for a long time. It is then that we find ourselves dealing with a serious situation and digitalis is indicated; however, we feel that cardiac failure is the only indication for digitalis in hyperthyroid heart disease. Certainly there is no reason to use it in simple tachycardia, while in the irregular rhythms without decompensation, it is merely a waste of digitalis. The incidence of heart failure in the Johns Hopkins Hospital series of 200 cases was about 18 per cent and in the Massachusetts General Hospital series about 4 per cent. In our series of 92 cases, however, we have had no instance of decompensation and hence we have had to use no digitalis.

It is well known that, in the event another type of heart disease already exists, hyperthyroidism may exaggerate the symptoms. This is true particularly of coronary heart disease and angina pectoris. The 75-year old patient seen in Plate I, for a number of years had had hypertension, coronary heart disease, and angina pectoris, which gave him severe pain several times a day. In June, 1937, it was discovered that he had hyperthyroidism, his basal metabolism at that time being plus 31 per cent. In August, 1937, a thyroidectomy was done, and for the two years since this time the patient has had very infrequent attacks of angina-like pain, and his general health has been improved.

When the question of treatment is considered, it should be remembered that hyperthyroidism is a variable disease, that remissions are not uncommon, and that no conclusion can be drawn as to the efficacy of treatment unless one observes a considerable number of patients over a period of years. Hyperthyroidism is best handled by one of wide experience who is prepared to follow each patient and treat him as an individual problem.

The importance of rest and sedatives in the medical treatment of hyperthyroidism is well recognized, and it is thought by some that, were we to follow more patients medically, we should find an increased number who show long remissions.

Apparently there is a type of young woman with a relatively mild hyperthyroidism (basal metabolic rate between plus 15 per cent and plus 30 per cent), who seems to do well on

medical treatment. About one year ago I saw a group of young women who were presented in the outpatient clinic of Massachusetts General Hospital, who seemed to have been in good health over a period of several years following medical treatment. The method of treatment was to administer saturated solution of sodium iodide, 6 drops daily, over an indefinite period of time. If the basal metabolic rate fell to zero or below, the iodine was withdrawn and the patient was observed further. As long as the metabolic rate stayed within normal limits no further treatment was given, but if it rose after withdrawal of iodine another course was prescribed. If the basal metabolic rate did not fall to zero, the patient was advised to have surgery. This group of young women comprised only about 5 per cent of all the cases of hyperthyroidism seen in the Massachusetts General Hospital clinic. In our clinic we have seen only one such young woman in the past year.

Before the institution of medical treatment the physician should secure a promise from the patient to abide by his decision, whatever it may be, for later treatment. It is well known that many patients are temporarily benefited by iodine and then show recurrence of symptoms and become resistant to treatment with iodine. Unfortunately, there are many hyperthyroid patients who have been observed and treated with iodine at short intervals by different physicians. This treatment tends only to confuse the picture, making it more difficult to evaluate the symptoms and signs and to institute treatment.

Treatment with x-ray is a controversial subject at present which I shall not attempt to go into in detail. Undoubtedly there are some patients who are very ill who can be prepared for operation with roentgen ray, although recently we have seen one die in the preparatory period, in spite of roentgen ray therapy. In some cases of recurrence of hyperthyroidism postoperatively, in which iodine does not give benefit, roentgen ray may be of great value. We have had a patient recently who showed postoperative recurrence, having been operated upon in Atlanta twenty years ago and in our clinic two years ago. Eight roentgen ray treatments were given over the thyroid and upper sternum at fortnightly intervals, beginning December 7, 1938, and

ending April 4, 1939. She now shows a remission and is in better health than she has been for many years. Apparently many cases of hyperthyroidism are entirely refractory to treatment with roentgen ray and others show only temporary benefit.

We think that in the great majority of cases the treatment of choice is surgery, although this method is certainly not perfect. The case just cited showed a recurrence after two operations had been performed by thoroughly experienced and competent thyroid surgeons.

It was in 1922 at Mayo Clinic that Plummer described his method for preparing the patient for surgery, and since that time this procedure or a slight modification has been universally accepted. Several years ago I was asked to examine a young woman preoperatively. Because she had a basal metabolic rate of approximately plus 75 per cent with all the classical symptoms of severe hyperthyroidism, in spite of having had intermittent iodine treatment before she was seen in our clinic, I made a note giving the opinion that in this case we should expect a stormy postoperative course, probably a typical thyroid storm. After careful preparation, however, the patient had an uneventful recovery following thyroidectomy. Correct preparation for operation can not be stressed too strongly; moreover, it can not be carried out by any rule of thumb. To know just when a patient has reached the optimal point in his preparation is a matter of experience and good judgment. We believe it is safest and wisest for the surgeon himself to supervise and be directly responsible for the preparation of his patient. The preoperative care as well as the surgical treatment will be discussed by Dr. Duncan Owens.

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## SURGICAL ASPECTS OF HYPERTHYROIDISM

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The thyroid gland begins as a medial down-growth of the entodermal lining of the anterior pharyngeal wall between the first and second branchial clefts. This point remains in adult life as the foramen cecum of the tongue. The thyroid bud grows downward as the thyroglossal duct until the region of the development of the hyoid bone is reached. There it bifurcates to form the lateral lobes joined by the isthmus. In its descent vestiges may be left to develop into aberrant thyroid tissue. These ectopic or aberrant thyroids may be situated anywhere along the course of descent from the base of the tongue and down into the thoracic cavity.

The thyroid obtains its blood supply from two paired arteries, the superior and inferior thyroid, and at times from the thyroidea ima. The superior is the first branch of the external carotid. The inferior arises from the subclavian as a branch of the thyroid axis. The thyroidea ima, when present, runs directly from the arch of the aorta to the isthmus of the gland. The veins leave their rich plexus, mainly from in front of the gland, as the superior, middle and inferior trunks. The superior

empties into the common facial, the middle inferiorly directly into the internal jugular, while the inferior anastomose freely with each other to form the infrahyoid plexus and thence to empty into the innominate. The entire nerve supply is from the cervical sympathetic ganglia, the fibres of which accompany the superior and inferior thyroid arteries. The parathyroid bodies and the recurrent laryngeal nerves are in close relation to the posterior surface of the thyroid gland but are outside of and posterior to the so-called capsule of the gland.

It is safe to say that there is a higher incidence of hyperthyroidism in the female sex, in the years from twenty to forty and in families. Beyond this point accuracy of observation cannot be guaranteed by any one. Plummer believes that there were waves of extremely high incidence following the influenza epidemics of 1899 and 1918. Crotti believes that a fungus infection causes hyperthyroidism. Certain it is that there are at times "activating episodes," such as acute infection and psychic phenomena.

Hyperthyroidism means, literally, hyperfunction of the thyroid gland; actually hyperfunction may be of the entire or only a part of the gland. When hyperfunction is the result of a generalized hyperplasia, we have the diffuse toxic goitre. In this form, generally the onset is fairly sudden and acute but may be slow and insidious. When, however, hyperfunction develops in a gland containing nodules, the result of hyperplasia either of the nodules or of the surrounding gland, we have the nodular toxic goitre. In this form the onset is more apt to be slow but may be sudden and acute. Because toxicity so frequently develops in glands that contain nodules it is recognized practice to remove these thyroids early as a prophylactic measure.

As subgroups under these two main divisions are three other forms of hyperthyroidism that must be borne in mind: the apathetic hyperthyroidism of Lahey, usually occurring in older ages with symptoms mild or veiled but with severe intoxication; the hyperthyroidism that masquerades as some other disease, especially heart disease; and the hyperthyroidism with low basal metabolic rate, the "chronic hyperthyroidism" of Poer.

Thus it readily will be seen that, though a



diagnosis is frequently easy to arrive at, very often it may be extremely difficult. Indeed, there is, perhaps, no condition that requires closer cooperation between the internist and the surgeon. It always must be borne in mind that spontaneous remissions occur. The cause of these remissions is not known but they are very similar to the artificial remissions induced by the administration of iodine. Such a case recently came under my observation: a man, 35 years of age, presented a typical picture of marked hyperthyroidism but his basal metabolic rate was minus 23. He was sent out of town for a fortnight's rest. While away he entered into a mild toxic crisis and almost three weeks were required to get him ready for operation. During this time his basal metabolic rate fell from plus 54 to plus 22 just before operation.

In approximately 80 per cent of cases the diagnosis is correctly made by the presence of the four cardinal signs and symptoms: (1) enlargement of the thyroid gland, (2) exophthalmos, (3) tachycardia and (4) excitability of the nervous system plus an elevated basal metabolic rate. In the remaining 20 per cent the diagnosis is more obscure and it is in this group that the acumen of both the internist and surgeon is most acutely tried. To keep ever in mind the possibility of hyperthyroidism is to miss the diagnosis in fewer cases.

Treatment of toxic goitre today resolves itself into either x-ray therapy or surgery, neither of which is ideal. Under x-ray therapy one can expect a cure in about one-third of cases; improvement of variable duration, with the ever-present possibility of recurrence, in another third; and no benefit in the last third. It carries no mortality of itself though patients have been known to die in a crisis during its course. It does not require hospitalization and so economically it is probably less expensive than surgery. Its greatest disadvantage is that in only about one-third of cases is a prompt and satisfactory result obtained. Recently, combined x-ray therapy of the thyroid gland and of the pituitary gland seems to hold out hope of a higher percentage of cures. Because one can expect prompt and satisfactory results in 80 per cent or more of cases subjected to modern operative procedures, in spite of its admitted mortality, in spite of its possible ill effects of hypoparathyroidism or

laryngeal palsy and in spite of the fact that in a low percentage of cases recurrent or residual toxicity has to be contended with, surgery is the treatment of choice today.

In no other condition amenable to surgery does preoperative care pay such dividends as in the patient suffering from toxic goitre. It may literally mean the difference between life and death, success or failure, cure or no relief. Iodine is our sheet anchor but other measures must not be neglected. Our routine is as follows: Intercurrent disease or infection is ruled out by means of careful history, physical examination and the use of the laboratory. Possible foci of infection are particularly searched for and, if found, eliminated. Electrocardiograms, x-ray examination for possible intrathoracic goitre and examination of the vocal cords are, with few exceptions, routine. The patient is given bed rest in as quiet surroundings as possible. This need not be in a hospital; indeed, the home is to be preferred to the average hospital ward. An accurate record is kept of the temperature, pulse respiration and especially of the weight. The basal metabolic rate is estimated at five-day intervals. A high caloric diet, rich in carbohydrates and of low residue, 4,000 to 5,000 calories per day with forcing of fluids, 3,000 to 5,000 cc. per day, is instituted. Beginning about one week before expected operation, daily rectal instillations of 200 to 300 cc. of 5 per cent glucose in normal saline solution are given. Of this more will be said later. Sedation, preferably by the use of bromides and only at times of barbiturates is given in dosage sufficient to allay nervousness and to insure rest and sleep. Digitalis is given in cardiac decompensation; even in auricular fibrillation only digitalis and not quinidine is used. Finally and most important is Lugol's solution given, minimis five to ten, four times daily. On this regimen in ten days to three weeks usually the pulse will drop, the basal metabolic rate will be lower and the patient will start to gain weight. At the end of three weeks the patient will have reached his maximum improvement. Occasionally one sees a patient who does not respond as expected under this regimen. In this type of case I have seen benefit from the daily hypodermic injection of 1 cc. of tissue extract, the anti-adrenal fraction of pancreatic extract.

The optimum time for operation is largely

a matter of experience and judgment and here again must come hearty cooperation between internist and surgeon. An attempt is made to obtain certain criteria: the pulse should be not above 90 per minute; the basal metabolic rate should not be above plus 40; the patient should not be losing weight; the thyroid gland should have become movable and softer; the heart should be in compensation. However, it is not essential that auricular fibrillation should have ceased; indeed, according to Lahey, the patient with auricular fibrillation is in desperate need of surgery and operation should not be delayed.

The choice of anesthetic is, to a great extent, a matter of personal choice so long as the patient reaches the operating room in a non-excited and, preferably, at least in an obtunded condition. The proponents of local anesthesia carefully obtund their patients with barbiturates, or avertin, and morphine. Their contention that one is able to have the patient talk to them and thereby know if the recurrent laryngeal nerve has been injured is well taken. Personally I prefer a basal anesthetic of avertin, not over 70 mg. per kilo of bodyweight, followed by cyclopropane anesthesia. This is carried out as follows: The same person who is to give the avertin gives the daily rectal instillation of glucose in saline and it is given at the same time it is planned to give the avertin. On the morning of operation the dose of avertin is substituted; the patient almost invariably goes to sleep in bed and awakens to find his thyroid gone. With cyclopropane a higher percentage of oxygen can be given than with any other form of inhalation anesthesia. This is important.

The use of iodine in the preoperative preparation of toxic goitre patients has largely done away with graded or multiple-stage operations. It is indeed doubtful if polar ligations, particularly of the more often tied superior arteries, had any result, even of diminishing to any extent the total blood supply. Its procedure was apparently based more on hope than on proof. Today multiple-stage or graded operations are done as an emergency measure because of the patient's condition on the operating table, and, electively, in those occasional patients, mentioned by Lahey, who have a low blood iodine and are notoriously bad risks and in those refractory to iodine or

iodine-fixed. Even under these circumstances polar ligations are seldom done, hemithyroidectomy being performed by preference. Boothby reported in 1935 from the Mayo Clinic that their incidence of graded operations had dropped from over 50 per cent to less than 2 per cent with an operative mortality of less than 1 per cent.

The ideal procedure undoubtedly is the removal at one sitting of approximately four-fifths of the gland substance, including the entire isthmus. This must be accomplished without injury to the recurrent laryngeal nerves and so as to leave the parathyroids and their blood supply intact. The simplest and safest way to insure against these accidents is to perform all maneuvers within that fascial sheath commonly called the capsule. This capsule lies between the gland proper and the ribbon muscles and is exposed when these muscles are retracted. The capsule is incised vertically over the most prominent part of the lobe and is freed from the anterolateral surface of the gland preferably by sharp dissection. When it is retracted it is quite easy to expose the superior pole, isolate there the superior vessels by blunt dissection, cut and doubly tie them. The middle veins are next cut and tied and the freeing of the capsule continued posteriorly and towards the lower pole. The anterior branch of the inferior artery is doubly ligated and cut when it comes into view. The inferior veins are ligated, usually en masse, and cut. The lobe can now easily be elevated, which facilitates the freeing, by blunt dissection, of the isthmus from the trachea. After division of the isthmus between clamps gentle traction is applied to the lobe so that, by inspection and palpation, its size and shape can be determined and the amount to be resected accurately decided upon. Thus, little guesswork comes into play; the recurrent laryngeal nerves and the parathyroids, lying without the capsule, are protected throughout the operation and the amount of tissue to be left is ascertained with certainty. During resection of the lobe the posterior branch of the inferior artery is secured, completing the control by ligation of the blood supply to that lobe. Drains, if used, seldom have to remain longer than twenty-four hours.

In the postoperative course the chief fear is the development of a crisis or storm. Proper



preoperative care has so lessened this risk that it is rare today. Definite warnings of its approach are: (1) a rising pulse, (2) extreme irritability, (3) hyperpyrexia, and (4) delirium. The best treatment is prophylactic by preoperative iodination and glycogenation. It is routine to give intravenous glucose post-operatively, 2000 cc. to 3000 cc. of a 5 per cent solution during the first twenty-four hours. The immediate treatment of the developing crisis or storm is sodium iodide intravenously, ice-bags, and oxygen tent. In spite of all measures postoperative crisis carries a very high mortality, 50 per cent to 70 per cent. Most patients complain of sore throat for several days postoperatively. The discomfort of this can be materially relieved by frequent steam inhalations, using compound tincture of benzoin, drams one to the quart of water.

Subtotal thyroidectomy, according to Thompson, Morris and Thompson, cures 80.5 per cent of patients suffering from toxic goitre. Of the remaining 19.5 per cent all but one showed improvement and in only two were there true recurrences, the remainder having either residual or persistent toxic symptoms. Collier and Potter report for diffuse toxic goitre over 90 per cent rehabilitation with only 9 per cent unrelieved; for nodular toxic goitre over 95 per cent rehabilitation. Most authors are agreed that the more extensive the resection the greater the probability of a cure, but practically all prefer to leave a modest amount of gland, one-fifth to one-sixth, to carry on thyroid function. That a very few come to further surgery is admitted. These are the small number of true recurrences and practically without exception they are cured by surgery, second recurrences being almost unknown. By far the greater number of surgical failures are of the residual or persistent toxic type. This type, Means agrees with Haines, can almost always be controlled by iodine therapy alone until the disease burns itself out.

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## DISCUSSION

*Dr. Frank G. Slaughter, Jacksonville:*

I am deeply grateful for the privilege of discussing these two very interesting papers. I think that hyperthyroidism is a subject to which we certainly cannot devote too much attention. All too frequently these conditions are overlooked, I think largely because of the fact that the classical symptoms and signs which we were taught in medical school would show us hyperthyroidism and show us toxic goiter do not do it at all. Probably the most persistent evidence we have of hyperthyroidism is exophthalmos, but this is not present in a large portion of the cases with enlargement of the thyroid gland.

I would like briefly to report a few statistics based on the surgical aspect of these 92 cases that Dr. Merritt talked about.

About anesthesia: I am very much interested in what Doctor Owens has to say. As he says, it is a matter of opinion, and we in our work at the Riverside Hospital do not believe in general anesthesia. We have used local anesthesia on, I think, all of these cases, certainly on about 85 or 90 of them, and in comparison with the privilege I had seven or eight years ago of studying some 50 or 60 cases under general anesthesia there is no question in my mind that local anesthesia is the method of choice as far as the operation, as far as the result, and as far as the condition of the patient after operation are concerned.

Perhaps others of you will prefer to use avertin. In my experience with avertin when it first came out, we used very large doses, 100 to 110 milligrams. Of course, no one uses that large dose now.

In the 92 cases reported only one had a general anesthetic, a boy of 14.

Of course complications are things that you don't like to have and therefore don't like to talk about, but I would like to mention briefly some of the complications that we have run into.

The question of thyroid storms: We see these cases less and less. In 60 cases treated during the past four years we have had two thyroid storms. One was in a man who had a hemithyroidectomy. The operation was stopped because the patient's condition was not good. The other was in a colored woman who was prepared under the supervision of the family doctor in another town and, we found out later, inaccurately prepared. Both of these cases fortunately came through all right.

We do not feel that graded operations are necessary in most cases, but they are necessary in some cases. In the above 60 cases they were not necessary.

Hemorrhage is mentioned only to impress on us the necessity of careful hemostasis during operation.

The question of paralysis of the vocal cords always is a hazard to thyroid surgery. However, the speaker has not yet paralyzed a vocal cord.

The question of using local anesthesia with the idea of being able to talk to the patient is stressed too much. The advantages of local anesthesia other than the ability to talk to your patient, we think, are tremendously great. Having the patient wake up and say, "Yes, Doctor, I feel fine," after the operation is not so important as we might think.

Something often overlooked in thyroid operations, is I think, the presence of the pyramidal lobe. Unless found it is quite possible to leave a section of tissue which will cause a recurrence. We have had that happen several times.

In the parathyroid injuries we have had a little trouble. In one case there was a rather severe parathyroid injury. The patient went into parathyroid tetany and was treated in the hospital with calcium and parathormone. This patient was followed carefully for six months, and when seen a year later had apparently recovered parathyroid function. I want to say that in the average case you do not see this particular complication after operation.

As Doctor Owens says, wherever possible the entire operation should be performed within the capsule of the gland, as this is the simplest method of preventing trauma and consequent disability.

We do see occasionally muscular cramps or little spasms after operation which we think possibly indicates that the parathyroids have been injured and not removed. To date all of them have turned out all right.

The most important thing in thyroid surgery, I think, is to be sufficiently radical in removing the gland. We believe that in the true case of hyperthyroidism you will err in not removing enough gland rather than in removing too much. The amount of gland necessary to carry on the function is surprisingly small considering the amount you can resect without the patient developing myxedema. Frequently myxedema following operation may be a good sign. It shows that you have taken out enough thyroid to take care of the disease and the myxedema will take care of itself with thyroid extract given very carefully.

*Dr. Fred Mathers, Orlando:*

I wish to emphasize a few of the points that were brought out by the speakers.

I think it is very necessary that the basal metabolism determinations be done by some skilled technician. This is the only way we can avoid error. The recent work on iodine tolerance is important both to diagnosis and prognosis. The clinical sign of warm, moist hands mentioned by Doctor Webster Merritt should be emphasized since this will aid in the differentiation of hyperthyroidism from neurocirculatory asthenia and autonomic nervous system imbalance.

In my experience the most severe cardiac disturbances, auricular fibrillation and cardiac decompensation, usually occur in older age groups.

Possibly the best use of iodine is to determine the diagnosis. The case then resolves itself into a problem of hypermetabolism and may be treated as such.

The preoperative importance of vitamin B and vitamin A has been recently recognized. Where liver damage is recognized in postoperative crises steps should be taken at once to replace this loss.

The method of basal anesthesia mentioned by Doctor Owens for patients already nervous and excitable is extremely important.

*Dr. Edward Jelks, Jacksonville:*

Hyperthyroidism may occur at almost any age. Since Doctor Merritt's report includes only patients in the Riverside Hospital, he did not mention that at the Duval County Hospital in Jacksonville last year, we treated a colored boy, 3½ years old, with frank hyperthyroidism.

He was operated upon eight months ago, and today his condition indicates that he is cured. Very few cases in individuals under 4 years of age have been reported. From a fairly comprehensive search of the literature, it was found that this patient is one of the youngest treated surgically.

Doctor Owens requested that I make some remarks on the use of iodine in hyperthyroidism. The opinions here expressed are based upon personal experience. Our opinion is that iodine is indicated in hyperthyroidism under the following circumstances:

1. In some cases of mild hyperthyroidism, especially among young women, very probably the treatment of election, as shown by Doctor Merritt, is small doses of iodine.

2. Sometimes when there is a mild degree of hyperthyroidism remaining following operation, small doses of iodine, 2 to 5 drops daily over long periods of time, may maintain a proper balance and enable the patient to perform normal activities.

3. There may be occasions when, because of economic conditions, it is impossible for an individual to have surgical treatment in spite of the fact that the doctor realizes that it is definitely indicated. Knowing that iodine may help the patient temporarily, it is perhaps permissible to prescribe it as a temporizing measure, but one should realize that this treatment is adopted through desperation rather than choice. Such giving of iodine can hardly be called an orthodox indication.

4. The chief use of iodine in hyperthyroidism is to prepare the patient for operation. Methods of doing this vary in different hospitals and in the hands of different men. One of the main points to remember in this matter is that, although there must be the closest co-operation between the internist or family physician and the surgeon during the operative and postoperative periods, I think the surgeon should have the opportunity of examining the patient before iodine is started. It is all right for someone else to administer the iodine, but the operator is at a great disadvantage if he examines the patient for the first time after the giving of iodine has been started. It is almost impossible for the surgeon to anticipate with a reasonable degree of certainty what problems he will encounter with each patient, unless he has the opportunity to estimate the degree of toxicity by seeing the patient before operative preparation has been begun. This knowledge helps one in the operating room to decide how much gland to remove. Certainly the surgeon is in need of every possible advantage.

Doctor Owens reported that usually about 80 per cent of the gland should be taken out. We remove at least 90 per cent. As time goes on, we remove more and more. It is sometimes thought that there will be a deleterious loss of function if too much of the gland is taken out. Our opinion is that the more one can excise without complications, the better off the patient is going to be. If the proper amount is removed. I don't think there is a group of patients with whom we get better results.

I shall not talk about the percentage of cures. Although it is difficult to determine exactly the results of treating people with hyperthyroidism, I am sure there is no group of patients with whom I have worked in the last ten years who are so grateful to the surgeon and doctor or so wonderfully restored to normal activity as those upon whom subtotal thyroidectomy has been performed for hyperthyroidism.

#### *Dr. Frank S. Adamo, Tampa:*

I know very little about the endocrine, but I would like to say something about the surgical phase of it. The mortality in children is very high when the whole gland is removed. Also in the non-activating or apathetic type we usually do a hemithyroidectomy.

We use a general anesthetic. If cyclopropane is used be sure that the anesthesia is deep enough, especially in thyrocardiac cases. If you do not have it deep enough, the cough reflex is not abolished and there is danger of strain upon the heart, a cause of increased mortality.

To determine the amount of gland to be removed, we are guided by the symptomatic response to iodine; that is, if the response to iodine is slight or none at all, then we remove about nine-tenths of the gland, while if the response is great, then we remove a lesser amount of the gland.

#### *Dr. Claude Anderson, Orlando:*

I would like to ask Doctor Owens to discuss the incidence of goitre in Florida as compared to the other regions of the country.

#### *Doctor W. Duncan Owens, (concluding):*

Answering Doctor Anderson's questions as to the incidence of hyperthyroidism in South Florida there were approximately 350 operations for hyperthyroidism in two of the major hospitals in the Miami area during the past ten years. Approximately 90 per cent of these patients were born outside of Dade County; 75 per cent outside of Florida. Of the patients born out of Dade County and out of Florida a great majority spent their early life out of Florida, moving to South Florida after having attained at least the 'teen age. Our figures compare rather closely with Doctor Merritt's as to incidence in males and females.

I do not wish to enter into a controversy regarding anesthesia but I have found that the basal type administered in the patient's own bed brings them to the operating room in the best possible condition for surgery.

### THE PROGNOSIS IN HEART DISEASE

JOSEPH G. SELTZER, M. D.

Orlando

Florida, because of its climate, more and more tends to draw persons suffering from heart disease as residents. In the great majority of cases these individuals have been made "heart-conscious" and often the resulting mental trauma has done more harm than the original cardiac disorder. The mental trauma may cause functional disorders ranging from mild neuroses to permanent invalidism.

In heart disease it must always be remembered that no matter what the underlying pathology, the prognosis depends almost entirely upon the condition of the myocardium. A healthy heart muscle can carry on in spite of tremendous and unbelievable handicaps while, on the other hand, a heart muscle of poor tone and quality has a tendency to break down with mild effort or worry. The prognosis must always be a guarded one and should be considered from two viewpoints, the immediate prognosis, and the final prognosis. The two prognoses are unrelated for one may be good and the other bad. An example of this is the toxic myocarditis seen in diphtheria or acute infectious diseases. The immediate prognosis in severe toxemias is poor but if the patient recovers and is kept in bed for an adequate period of time, his final prognosis is



good and he may live out his full span of years and show no signs of heart disease. On the other hand, in rheumatic carditis the immediate prognosis is good and yet the ultimate prognosis is poor in that some damage has been done which later will cause circulatory disorders and possible failure and thus shorten life.

#### NEUROCIRCULATORY ASTHENIA

This is a very important condition of instability and abnormal irritability of the nervous and circulatory systems, of unknown cause. In this condition the patient complains of his heart and yet no organic disease is present. It is almost an invariable rule that when a patient complains directly about his heart no organic disease can be found and the prognosis is good in regard to the probable duration of life. However, because of the patient's symptoms his whole life may be altered and the condition cause the patient to lead an abnormal existence. The heart in this condition is usually disturbed by either nervous or toxic influences but is itself not diseased. Rather, there is a functional circulatory disorder and only occasionally is it associated with heart disease.

Effort syndrome may occur in perfectly normal persons but when it is of high degree and the symptoms are marked, it is of significance since it can become a factor in incapacitating the patient and, secondly, it can simulate or complicate heart disease. Although this condition is found in civilian life it is much more frequent in armies during war-time. Since the condition is most common in young adults at which age the myocardium is in good condition in the majority of these patients, the prognosis with organic diseases excluded is excellent. The prognosis improves when the patient is placed on restricted diet, psychoanalyzed, and mild sedatives are given.

#### DISTURBANCES IN CARDIAC RHYTHM

Cardiac irregularities often give rise to unnecessary anxiety and incorrect diagnoses. Although the great proportion of cardiac abnormalities consist of extrasystoles and paroxysmal tachycardia and are as a rule of a simple etiological cause, some irregularities are exceptionally serious. Cardiac irregularities are all related in mechanism. Since they are found frequently and their likelihood is often over-emphasized, these disturbances

form a very important subject in cardiac prognosis.

James Mackenzie was the first to recognize and separate the various types of irregularities of the heart. The slighter forms of cardiac irregularities, such as sinus arrhythmia and premature systoles, usually occur in individuals showing no signs of organic diseases. However, in heart block organic disease is commonly found.

1—Extrasystoles are premature beats.—They are due to abnormal stimuli arising in various parts of the heart. They may arise in the auricles, ventricles, auriculoventricular bundles, and even in the nodes themselves. The chief factor of this condition is the prematurity of the beat. This condition is almost universal and very rarely does anyone escape having premature beats at some time in his life, although they pass unnoticed, undoubtedly the most common of all cardiac abnormalities. In fact, it is so frequent that it should not be called an abnormality.

These premature ectopic beats may come singly or in groups and in groups are usually seen as a form of paroxysmal tachycardia. Occasionally cases are seen where the pulse rate at the wrist is exactly one-half of the heart rate, an extrasystole occurring after every normal beat which fails to reach the wrist. Extrasystoles, in the absence of other signs, as has been mentioned before, mean very little. They are probably toxic in origin or can come from indigestion, or abuse in the use of tea, coffee, or tobacco. They occasionally can be found to complicate organic disease but in these cases it is the organic disease itself that makes the prognosis grave. It is claimed that premature beats are relatively more numerous in the presence of heart disease due to the fact that the heart muscles are under a strain.

2—Sinus arrhythmia.—Here the heart rate is constantly varying, chiefly in response to respiration. It is most frequently seen in childhood and early adulthood. The condition has no significance and at one time it was believed to be a sign of a healthy heart muscle.

3—Auricular fibrillation.—This is one of the most common important disorders of cardiac rhythm. Fundamentally it is a disturbance arising in the auricles, usually attended by absolute irregularity of the ventricles. It ranks



third in frequency in the cardiac irregularities, the first two being premature beats and paroxysmal tachycardia. It may be a passing condition due to toxemia as seen in Basedow's disease, but otherwise means myocardial damage and is of grave significance. Auricular fibrillation is by no means a constant condition. It is frequently paroxysmal in nature although once established for a period of several weeks it does tend to persist. Fortunately, its bad effects on the ventricles can usually be controlled by digitalis. Digitalis tends to cause intra-auricular block by increasing the refractory period due to its direct action on the auricular muscle, and in addition it tends to increase the rate and irregularity of the circus movement and to shorten or hasten its course by decreasing the refractory period of the muscle through vagal action. In addition, the condition may be removed by the use of quinidine sulfate. The auricles have little influence in the general circulation and if the ventricles are not unduly disturbed the patient may fibrillate for many years without becoming an invalid. Fibrillation throws an extra load on the heart and if it is well borne the heart muscle is in fair condition while if embarrassment follows, the heart muscle condition is poor. Auricular fibrillation may be of minor importance or may be very serious. It occurs in people without heart disease and may be disagreeable but nothing more. Untreated paroxysms usually last a few hours, several days and very rarely a few weeks. Even in the permanent form it may cause little or no disability. Cases are on record where patients have gone thirty or more years from the time of diagnosis. Long lives, full of activity, may be carried on through the proper use of quinidine and digitalis.

4—Auricular flutter.—Although this is a cardiac irregularity its important significance is that of myocardial disease and as such is very serious. It is usually difficult to diagnose without the use of an electrocardiograph. Individuals suffering from auricular flutter may have the condition for a long time and yet scarcely be aware of the disease if the ventricular response to the bombardment of impulses from the auricles is not too frequent. This is due to a lowering of the conduction and is a defensive mechanism in sparing the ventricles. However, from time to time the block is lifted and at this time the ventricles

beat rapidly. An attack of this sort simulates paroxysmal tachycardia and may last from moments to days. In severe cases signs of failure appear and may even go on into death. The use of massive doses of digitalis changes the rhythm to fibrillation and then when the digitalis is eliminated the rhythm returns to normal. However, one attack of flutter predisposes to future attacks.

5—Heart block.—Heart block is primarily the result of depression of the specialized tissues that normally initiate the heart beat and conduct it to the muscles of both ventricles. This is in contrast to the abnormal cardiac rhythms due to unusual excitability and stimulation. When the sino-auricular node is much depressed we have sino-auricular block. If the lower nodal pacemaker initiates occasional beats we speak of ventricular escape, and if it controls the ventricular rhythm entirely it is called idioventricular rhythm. When it controls auricular as well as ventricular action it is known as auriculoventricular nodal rhythm. Delay of the impulse in the bundle branches is bundle branch block. The various forms of block may be due to toxemia, digitalis poisoning, rheumatic fever, acute infectious diseases, etc. When due to these causes, they clear up when the poisons are eliminated or disappear. The other causes are probably organic and, with the exception of the syphilitic form, usually persist. Heart block occurs in all degrees from mere delay in conduction to complete auricular and ventricular dissociation. However, as mentioned before, the seriousness of the condition depends on the degree of involvement of the heart muscle. If the changes are confined largely to the mechanism of the auriculoventricular bundle the chief danger is the Stokes-Adams' syndrome. These seizures are usually seen when the block is incomplete but when the block becomes complete the patient passes into a state of comparative comfort. Occasional cases may go on for years, but the majority of patients die either in a syncopal attack or heart failure.

6—Pulsus alternans.—One of the most important abnormalities of the peripheral arterial pulse and indicative of a failing heart muscle is pulsus alternans. It consists of alternation of large and small pulse waves with normal rhythm. There may or may not be signs of congestive failure. However, their very ab-

sence makes the sign of pulsus alternans all the more valuable because of its relatively early appearance in some cases. It is most often found in older persons and is rarely seen before the age of forty. It is generally found in the presence of serious organic heart disease without early or advanced failure, especially hypertensive heart disease, coronary thrombosis, and aortic regurgitation. Hypertension is usually present. The lower the blood pressure and the slower the pulse rate the more serious is the finding of pulsus alternans. Occasionally with extreme tachycardia and in the absence of heart disease, pulsus alternans may occur and indicate fatigue only. When pulsus alternans develops in elderly patients they seldom live beyond six months.

#### ORGANIC HEART DISEASE

1—Acute diseases.—These diseases have an unimportant effect on the heart and only occasionally may a few of them cause serious heart disease. A previously healthy heart may be attacked by some local infection with extremely little chronic effect, even when the heart involvement has been severe. Survival almost invariably means escape from any permanent or serious heart disease. Slight lesions may persist for years. Usually when a heart condition appears in the course of an acute toxic illness the course is short and fatal or long and exhausting with a doubtful prognosis. Although about one-half of such patients recover they are not out of danger for weeks and they may die suddenly at any time during the period of convalescence. Heart block is usually a fatal sign. Diphtheria, the most important of the acute toxic diseases, is infrequently seen today due to the use of antitoxins.

In acute cardiac infections it is now well realized that it is the extent of involvement of the myocardium that decides both the immediate and final outlook. Rheumatic fever is the most common form of such infection and today is one of the most important and difficult problems with which the world of medicine has to contend. Although this type of heart disease is comparatively rare in Florida, it is extremely common in the North. This condition is one of the chief factors in the crippling and killing of children and young adults. In exceptional cases rheumatic fever may so completely involve the heart muscle that death

occurs in the acute stage. As a rule, it is seen only in children in this degree of severity. In the great majority of instances it is the endocardium and less often the pericardium that bears the brunt of the attack and recovery is the rule. The myocardium is nearly always involved, and in addition some structural damage always remains in the form of a deformed valve or an adherent pericardium. Years later, after the attack has been forgotten, these structural changes may eventually lead to the breakdown of the heart reserve and go on to failure and death. It can be said that the immediate prognosis in acute carditis of rheumatic origin is good but the final prognosis is doubtful and poor.

In the more acute infections, such as gonococcus, *Streptococcus hemolyticus* and *staphylococcus*, the outlook is poor and death usually occurs rapidly. Subacute endocarditis is usually fatal but in rare cases a complete recovery can ensue.

Syphilis is one of the most common infections of the heart. By the time the diagnosis of cardiovascular syphilis is made it is usually a very serious condition. Most patients with acquired syphilis do not develop cardiovascular disease; at least 90 per cent never show clinical or pathological evidence of such involvement. Heart disease of the congenital syphilitic type is not common. The factor of early and satisfactory treatment of the original syphilitic infection is of the utmost importance as it concerns the later development of cardiovascular disease of syphilitic origin. Adequate treatment protects the majority of patients against the subsequent development of a syphilitic heart. The onset of the condition is slow and insidious and usually does not come to light for many years. Usually after discovery of the trouble death occurs within a few months to several years. Death occurs suddenly with or without preceding angina or from congestive heart failure. The average duration of life from time of diagnosis is two to three years. The most important factor of all in controlling the prognosis is the degree of physical activity of the patient. The more strenuous the life the shorter it will be, careful existence prolonging life many years more. The prognosis may be made worse from too vigorous therapy and death has followed from overtreatment in a few cases.



2—Chronic heart disease.—Where signs of chronic heart trouble are found such as hypertrophy, alteration in the heart sounds, etc., the question of prognosis depends chiefly on the condition of the myocardium. Of all the structural abnormalities of the heart, enlargement is the most common and most important. It can usually be taken as an index of the degree of cardiac strain, a very large heart indicating a great burden, and a poor prognosis; while a small heart indicates a small degree of heart strain and a good prognosis except in the presence of serious coronary disease. However, very important heart diseases may be present with little or no enlargement as is seen in aortitis, angina pectoris, and coronary thrombosis. Usually if a diseased heart is enlarged it is a very important prognostic sign.

Although murmurs are of extreme importance in diagnosis they may mean little or nothing as long as the heart muscle is pumping as an efficient unit and may only hamper or increase the work of the heart muscle. In conditions of this sort the prognosis must be based upon the efficiency of the heart muscle and not on the murmurs. The auricles may be inefficient as is seen in fibrillation and yet sufficient circulation is given to the body if the ventricles can do their work. In regard to the development of valvular lesions and murmurs which show their presence it may be said that systolic murmurs are of little significance. Especially is this true of pulmonary systolic blow which is common in run-down conditions and disappears when the tone of the body is improved. A mitral systolic bruit means leakage back into the auricle. It may be temporary or permanent and is of slight importance in the appearance of hypertrophy and even then must not be emphasized to any great extent. In the ordinary patient a systolic murmur means little unless accompanied by a thrill, when it has definite bearing on the future prognosis.

Diastolic murmurs are more important in the mitral area. They signify stenosis and usually mean progressive narrowing. Such patients seldom live beyond the age of fifty. Aortic regurgitation is usually very serious and the seriousness depends upon the amount of valvular incompetency which can be judged very roughly by the amount of pulse pressure and extent of a water-hammer pulse.

Precordial indrawing during systole of the heart usually means extensive pericardial adhesions and this hampers the heart.

In all cases of chronic heart disease it is necessary to find out how the heart bears up under strain. The taking of a routine history and the performance of a thorough physical examination is of utmost importance in deciding the prognosis. Frequently heart conditions are picked up in the course of a physical examination when the patient has been unaware that he has had a lesion. Many cases of heart failure show auricular fibrillation and this extra handicap probably precipitated the breakdown. If failure occurs when the rhythm is regular, the myocardium is far gone and such patients seldom last more than eight months after the appearance of edema. After the history and physical examination have been carried out, tests should follow to show the amount of heart reserve. These tests are of extreme value and consist chiefly of carefully regulated physical exercise. Physical exercise tests are of great importance in judging the prognosis. People who develop organic disease of the heart in early life live longer than do those in whom it occurs later on. In determining the prognosis of a heart case each individual must be judged separately and in addition to the factors enumerated, the occupation and habits of the individual should be considered. Patients with bad lesions may live for many years if there is no undue physical strain and the personal habits tend toward sparing the myocardium.

3—Angina pectoris.—Coronary insufficiency is shown by symptoms so definite that it is regarded as a disease entity and called angina pectoris. It consists of the sensation of paroxysmal oppression in the thorax, usually in the upper or middle sternum, brought on by exertion, persisting for a few minutes and frequently radiating to the arms. It is frequently known as stenocardia. It is true that angina pectoris is usually easy to diagnose. Angina pectoris is a common symptom and is more common today than it was in the past. This is probably due to the added strain of modern existence and habits that have developed in the last generation or two. Angina pectoris usually appears in people past middle age but is occasionally seen in the early thirties, with or without luetic aortitis.



Before the age of thirty the condition is extremely rare and if it occurs it is found in individuals with rheumatic hearts and marked aortic regurgitation. It is more common in the male sex and today is chiefly found in professional and business men who eat too much and exercise too little. It is relatively uncommon in the laborer or farmer.

Patients with angina pectoris often have a high blood pressure but this is not necessarily the case. The prognosis is worse when the attacks come on in the absence of high blood pressure. The prognosis depends upon many things such as the pathology of the underlying cause, the circumstances provoking the attack, the nature of the attack itself, and the condition of the heart apart from the seizures. It is exceptional for a first attack to be fatal and the majority of sufferers do not die in an attack but from heart failure later on. Many individuals have only one attack or else a few attacks and then go on without any further trouble. The pain of angina is a protective warning and if the patient heeds the pain he may escape further attacks. The older the patient, the shorter is his life after the onset of angina pectoris.

The nervous state of the patient is of some value in determining the prognosis. In the sensitive and nervous patient, the prognosis is less serious for it takes much less pathological change to cause the appearance of symptoms than in one who is calm.

4—Coronary thrombosis.—Coronary thrombosis is a very frequent and important cause of heart trouble near the end of life's cycle. In addition it cripples and kills often in the prime of life and sometimes even in youth. It is one phase of coronary disease that if slow in development may occur with no auricular symptoms and signs. The prognosis of coronary heart trouble is extremely variable and each case is a clinical entity in itself. The condition may be discovered only on post-mortem examination after the death from ripe old age or signs may be so marked that it may kill suddenly in a few hours. The prognosis depends not only on the degree and speed of involvement of the myocardium, but also on the treatment and the reserve strength of the heart.

When coronary thrombosis is recognized clinically the prognosis is always grave. Most patients survive the immediate attack and one-

half of the total survive for years, a few even for ten years or more. In the longest-lived proved case the patient survived 17½ years and White reports a case in which death occurred 24 years after the first attack. The prognosis is made worse by the findings of advanced age, a sudden and prolonged fall in blood pressure, duration of severe substernal pain for more than twelve hours, fever for a week or more, a high leukocytosis, rapid and marked cardiac dilatation, gallop rhythm, heart block, pulmonary edema, and embolic phenomena.

From postmortem findings it has been conclusively proved that in most cases of coronary obstruction the condition is not recognized and does little harm; only in the very severe cases do arresting symptoms occur. The larger the arterial block and the more suddenly this occurs, the graver will be the case. The electrocardiograph is of great value in the diagnosis of these cases. Negative tracings may occur when the disease is present but serial electrocardiography—that is, a series of electrocardiograms taken at short intervals—will probably show it up by RT-segment and T-wave changes. The electrocardiograph is a valuable aid in helping establish the diagnosis in doubtful cases, but is of little help in determining the prognosis. Cases with severe symptoms sometimes show little or no electrocardiographic changes while in other cases there are a few symptoms with marked changes in the electrocardiogram.

#### CONCLUSION

The prognosis in a cardiac patient should always be a guarded one. Many cardiac patients keep going year after year and in spite of all the law of averages, live out many unexpected years. Physicians treating patients with heart disease should always be optimistic in their viewpoint to and with the patient. Gloomy views can and do precipitate heart failure and cause cardiac neuroses.

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## A REVIEW OF SYPHILIS AT THE STATE HOSPITAL

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The syphilitic patients reviewed include all new patients admitted to the institution with a diagnosis of syphilis from the period of July 1, 1936, to July 1, 1938. During this period a total of 1,690 new patients were admitted to the state hospital and 389, or 23 per cent, were given a diagnosis of syphilis.

I am making no attempt to advocate any special type of therapy. The release rate does not present a true picture as some of the patients have been in the institution only from four to five months and adequate therapy has not been carried out. The release rates and death rates have, however, been carried forward to present date and this gives a three and one-half month period for such therapy as was instituted. The true picture presented on the chart deals largely with the number of patients admitted, the serological findings and classification dealing chiefly with the paretic.

Out of 389 syphilitic patients admitted 135, or approximately 35 per cent were colored males; 104, or 26 per cent, colored females; 95 or 24 per cent, were white males; and 55, or 15 per cent, white females, the highest percentage being in colored males. Of the 389 patients admitted positive blood and spinal fluid findings were noted in 206, or 53 per cent, the highest percentage of positives occurring in the white male group with 68 out of 95, 72 per cent. The white females followed

with 58 per cent, the colored males with 49 per cent, the colored females showing the lowest incidence with 38 per cent. Of the total of 389 syphilitic patients 19 were blood negative and spinal positive, giving a total of 58 per cent with positive spinal fluid involvement.

There was a total of 153 with positive blood and negative spinal findings, the highest percentage, 57 per cent, occurring in the colored female patients. In 11 patients out of the 389 a diagnosis of syphilis was made with both spinal fluid and blood serology negative.

In the classification of the type of mental disorder produced in these syphilitics 49 per cent were definitely classified in the meningo-encephalitic or paretic group, the highest relative rate occurring in the white male with 61 per cent. A definite diagnosis of meningo-vascular syphilis was made in 4 per cent; only 1 per cent was classified as congenital syphilis. However, other patients in the mental deficiency group might fall into this classification provided a detailed history were obtainable. It is interesting to note that syphilis was found in 108 patients, 28 per cent, admitted with a diagnosis of other mental disorders. The majority of these patients were picked up on routine blood examination. While some of these mental disorders may have been due to syphilis simulating functional and other organic psychoses, the large majority of spinal fluid findings were negative. Syphilis may have been, and in many patients was, an aggravating factor in precipitating a functional or other organic type of mental disorder.

The greatest incidence of syphilis was found in the manic depressive and dementia praecox groups. In the alcoholic group only 14 were found to have syphilis, one-half of these occurring in the white men. Three patients having no psychosis were syphilitic.

Out of all syphilitics admitted in the period 26 per cent were released. Less than half were serologically improved but the majority showed some degree of mental improvement. Undoubtedly many will return. It is difficult to get the normal person to realize the necessity of continued and prolonged treatment so we cannot expect too much of the improved syphilitic in this respect. All patients and a relative or guardian are advised prior to release on furlough of the presence of syphilis and of the necessity of the patient being placed under the care of a physician for follow-up

therapy. We are always glad to furnish any physician with complete data on these patients.

Out of these 389 patients 67, 17 per cent, died. We found the average age of the "spinal positives" to be 39 years and there was little variation in each group. Two patients with juvenile paresis were recorded, these occurring in the white female group. Of the total of 101 patients released 47, 20 per cent, had positive spinal fluid findings when admitted. The greatest incidence of releases in spinal positives occurred in white males which might be expected since they show the highest number of admissions.

Of the total number of syphilitics 136, 35 per cent, received malarial therapy. A greater percentage will receive this treatment if their physical condition warrants, and as our limited facilities permit. Of the 47 patients

released who were spinal positive, 30 had received the benefit of malarial therapy. All patients admitted to the state hospital routinely have blood Kline and Kahn tests made. A spinal serology and cell count is done routinely on all new admissions unless there is a definite contraindication.

In the presence of positive blood findings or any findings indicative of syphilis a colloidal gold and globulin is made on the spinal fluid. We consider a spinal fluid cell count of 10 as top normal. However, many authorities consider a cell count of 2-3 as normal and as many as five cells as suspicious. Our laboratory rather consistently reports our normal spinal fluid cell counts as 5 and we accept cell counts above 5 as suspicious and over 10 as worthy of extensive investigation from the luetic standpoint.

White states that the number of cells seems

NEW ADMISSIONS 1690  
SYPHILITIC ..... 23%  
SYPHILITICS — JULY, 1936-1938  
FLORIDA STATE HOSPITAL

	WHITE		COLORED		TOTAL	PERCENTAGE
	FEMALE	MALE	FEMALE	MALE		
Total Admitted	55 15%	95 24%	104 26%	135 35%	389	
Positive Blood—Pos. Spinal	32 58%	68 72%	40 38%	66 49%	206	53%
Negative Blood—Pos. Spinal	1 2%	5 5%	3 3%	10 7%	19	5%
Positive Blood—Neg. Spinal	21 38%	17 18%	59 57%	56 42%	153	39%
Negative Blood—Neg. Spinal	1 2%	5 5%	2 2%	3 2%	11	3%
Meningo-enceph. (Paretic)	23 42%	58 61%	38 36%	71 52%	190	49%
Meningo-Vascular Type	2	3	2	10	17	4%
Congenital	0	2	1	1	4	1%
With Other Mental Disease	16	21	40	31	108	28%
Discharged	4	6	6	10	26	7%
Furloughed	12	22	17	17	68	17%
Escaped	0	4	1	2	7	2%
Total	16 29%	32 33%	24 23%	29 14%	101	26%
Died	7	13	21	26	67	17%
Average Age Spinal Pos.	36 yrs.	41 yrs.	37 yrs.	42 yrs.	39 yrs.	—
Releases—Spinal Pos.	7	23	9	8	47	20%
Received Malarial Therapy	24	56	20	36	136	35%

SYPHILIS WITH OTHER MENTAL DISEASE

	MANIAC D.	D. PRAECOX	SENILE	MENT. DEF.	ALCOHOLIC	EPILEPTIC	DRUG ADD.	TOXIC	NO. PSYCH.	TOTAL
White Female	5	2	1	4	2	0	0	1	1	16 4%
White Male	2	4	4	2	7	2	0	0	0	21 5%
Col. Female	18	9	5	3	2	2	1	0	0	40 10%
Col. Male	4	12	7	3	3	0	0	0	2	31 8%
Total	29	27	17	12	14	4	1	1	3	108 27%



to bear a definite relation to the activity of the underlying irritation or inflammation rather than to the type and the acute cases of cerebrospinal syphilis will show many cells in the spinal fluid, also that lymphocytosis may occur in the spinal fluid as early as two months after the initial infection. A definite history of syphilitic infection is more often unobtainable or unreliable in the mental patient than the normal patient. We are usually forced to rely mainly on physical findings and serological tests. We feel that a single positive blood serology without other evidence of syphilis is open to question and these are repeated in our laboratory or sent to another laboratory. We do not ignore a persistently positive blood serology and prefer to give treatment when in doubt.

In treating the syphilitic we rely mainly on the following: malarial therapy, bismuth, neoarsphenamine, tryparsamide, potassium iodide, mapharsen, and sulfarsphenamine.

Malarial therapy is given to the paretics as first choice provided their physical condition permits and in the absence of cardiovascular renal disease, pulmonary complications, and any other debilitating conditions. A satisfactory course of treatment consists of at least 20 paroxysms with temperature reaching 104 F. We do not limit malarial therapy to the paretic group, but administer it to other patients with long standing syphilis and the majority of such infections are of long standing. Doctor Boyd states that English investigations have reported findings that indicate malarial therapy has a definite prophylactic value in preventing the development of paresis. Chemotherapy is often given before, and always following, malaria. Many patients are given preliminary therapy, usually of bismuth and tryparsamide, in order to improve their condition for malarial therapy.

We attempt to keep our patients on some type of continuous treatment without rest for at least 52 weeks provided they tolerate it well. We do not use excessively large doses but are rather inclined to small doses over a long period of time, frequently switching from one drug to another. Bismuth and arsenicals are given in combination and then in alternate courses. Periodical blood serology is done every 3-6 months and spinal fluid studies every 6-12 months or more often as indicated. In the paretic who is thin and in poor physical condition tryparsamide is often used starting

with 1 gram weekly and increasing to 2-3 grams weekly for 16-32 or more injections. Bismuth is often given in conjunction with tryparsamide. We are careful to observe the patient for visual disturbances during the first ten injections of tryparsamide. It will often improve the paretic and he will put on weight and look much better. It is only applicable to the treatment of neurosyphilis and especially to the paretic.

In concluding may I say that we do not expect a cure in the neurosyphilitic or the paretic. Most authorities agree that the paretic is never cured even though his cure is apparent insofar as his serology, mental condition, and physical findings may be concerned. Relapses are serious and response to therapy following relapse is usually poor and frequently not at all. Many patients rapidly become worse and die. When syphilis involves the nervous system, in view of the difficulty of reaching these structures effectively with any known drug, it seems that the best we can hope for is to arrest the process or try to maintain improvement or remission, so that the patient can make a social adjustment.

It seems to me that the hope for cure lies largely in prophylaxis. I sometimes wonder if we, as physicians, lay enough emphasis on immediate prophylaxis and instruct any of our patients along this line. Quoting from Ashburn, Moore and Youngs' *Results of Prophylaxis in the World War*, 242,000 prophylactic treatments showed the percentage of failures to be only 1.3 per cent; there was 1 infection in 37 exposures without prophylaxis; 1 infection in 274 exposures where prophylaxis was carried out; a 7-1 difference in favor of prophylaxis. Reasoner states that soap and water have been shown to have a powerful germicidal and solvent action on the spirochete, superior to many disinfectants. Combined with calomel ointment and with proper instructions as to use, it seems we might go far along this line in reducing the incidence of syphilis.

#### SUMMARY

1. Out of 1,690 new patients admitted to the Florida State Hospital in two years, 23 per cent were found to have syphilis.
2. Forty-nine per cent were classified in the meningo-encephalitic paretic groups with the greatest incidence occurring in white men and the lowest incidence in colored women.

3. Twenty-eight per cent were found to have syphilis who were diagnosed as suffering primarily with other mental disorders.

4. Treatment does not effect a cure of the paretic and relapses often show no response to further treatment and they frequently become worse.

5. More stress along prophylactic lines would appear to be of some advantage in reducing the incidence of syphilis.

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### COMMON FOOT AILMENTS

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There is no part of the human body which produces so much discomfort and disability, and at the same time is given so little scientific consideration, as painful feet.

Few phases of orthopedic surgery are subject to more controversy than that of flat feet. The differences of opinion are great, not only as to treatment but also the pathology of this condition. This may in part explain the fact that only a small percentage of such patients are treated by qualified physicians, the vast majority falling into the hands of non-professional agencies. Too often they are given insufficient study by the busy practitioner and are encouraged or even forced to seek relief elsewhere.

The foot is made up of a group of small, spongy bones arranged in a system of arches, and held together by ligaments and muscles. The arches also provide necessary space for the passage of nerves and blood vessels forward to the toes.

The longitudinal arch extends from the calcaneus to the head of the first metatarsal. It is maintained by the bony segments being attached to each other on the side of the concavity of the arch by their various ligaments, the plantar ligament, and the short muscles of the sole of the foot. Muscles having origin in the leg and insertion into the foot act chiefly

to hold the leg bones vertical by light tonal tension, although the tibialis posterior, passing under the highest part of the arch and being attached anterolaterally to the plantar surface of the foot, may have some supporting effect.

When the postural muscles of the longitudinal arch become unable to fulfill their function, a ligamentous strain arises which in turn gives the first symptoms of flat foot. The muscles may prove defective (1) when there is a general muscular hypotonus as in convalescence following illness or childbirth; (2) when normal muscles are excessively fatigued, as in occupations which require excessive walking or standing or a rapid increase in body weight; and (3), by continued wearing of incorrect shoes. Predisposing factors may include bad walking, improper standing and circulatory disturbances in legs and feet.

The foot is held in the plantigrade position by the supinators. Weakness of these supinators causes the heel to sag into pronation under the body weight. As the ligaments yield, the tarsal bones change position and as the long and short plantar ligaments gradually yield, a hypermobility of all the tarsal bones results. Since the forefoot cannot follow the heel into pronation because of counter pressure of the ground, it is forced into a position of relative supination. This takes place at the tarsal-metatarsal joints and causes a flattening of both transverse and longitudinal arches because of the importance of the head of the first metatarsal in both. The forefoot is further forced outward into abduction in walking. Thus it is seen that lowering of the arches is a result of the above factors, rather than the origin of flat foot.

In neglected cases three further changes take place: the displaced bones are gradually altered in shape; portions of the joint surfaces undergo fibrosis; and the chronically strained muscles become spastic and the ligaments retract. Thus the hypermobility of the foot disappears and the spastic flat foot is encountered.

The first symptoms are burning and excess perspiration. This is shortly followed by stiffness and lameness. The feet usually are most uncomfortable on arising in the morning, or after a period of rest. Excessive exercise or long periods of standing give greater discomfort. The gait becomes inelastic and there is



a tendency to walk with the toes pointed outward and not to rise on the toes. In the next stage, the pain is worse when standing than when walking, because walking involves chiefly the use of muscles. On standing, the weak muscles relax, allowing the whole body weight to be borne by the weakened ligaments. Pain may be found anywhere over the posterior half of the foot in the neighborhood of a ligamentous attachment. The more common areas of tenderness are over the navicular, the calcaneonavicular ligament, the sole of the foot and frequently below the head of the first metatarsal.

The effect and symptoms of flat foot are not always limited to the feet. Symptoms may arise from a further disturbance of the static equilibrium of the body. Pain in the knees, hips and back are not infrequently encountered. Treatment is directed towards the correction of all sources of pain and disability. Superficial lesions, such as corns, callouses, infection, etc., should be eradicated.

Since the acquired flat foot is caused by muscular weakness, the prevention and treatment of this condition must be directed towards a strengthening of the muscles involved, particularly by the supinators and the short sole muscles. Gymnastics are the best means of accomplishing this purpose, but usually cannot be done over a sufficient period of time to give complete cure without mechanical aid. Many systems of exercises have been tried and quite a number of pieces of complicated and expensive apparatus devised in an attempt to aid in the regeneration of the weakened muscles. The most beneficial single exercise is one which necessitates a gripping action of the foot, thus exercising particularly the sole muscles. This may take the form of picking up small objects with the toes while sitting on a chair. The next most beneficial exercise is drawing the foot into inversion or varus and dorsiflexion. No weight bearing exercises should be given during the early course of treatment.

The style and fit of the shoes being worn should be checked. The most satisfactory type of shoe for men is made of a soft leather, such as kangaroo, fits snugly in the heel, has a narrow, semi-flexible shank, practically straight inner border on the sole, and plenty of toe room. Women's shoes are a difficult problem because of the present ideas as to

style. They should have ample length and toe space, a straight inner border to the sole which is wide enough to allow all the metatarsal heads to lie flat on its surface without overhanging. The heel must fit snugly and have an elevation of not over  $1\frac{1}{4}$  inches. All these requirements can be met only in an oxford type shoe.

Unless the feet are in the most advanced stages of strain, patients seem to expect to step into some sort of corrective shoe and go on about their daily duties. Other diseases and injuries are treated by bed rest or limitation of activity, but such cooperation is too often lacking in people suffering from strained feet. A reasonable curtailment of weight bearing is essential during the painful stages. Improvement in circulation may give marked relief from symptoms and is important in combating muscular fatigue. Contrast foot baths are best for this and are easily available to all at no cost. These should be taken before the exercises twice daily, and should have a specified duration, usually one-half hour. Massage, baking and diathermy are also indicated.

The types of mechanical arch supports and corrective shoes are so numerous that it is next to impossible, and certainly of no benefit, to describe them all. The great number of different appliances is mute evidence of numerous failures to relieve these patients. Each type is probably of some value in properly selected cases, but no one is a "cure all." The main point of difference seems to be whether the semi-flexible or rigid shank is preferable. For the usual case, I prefer the semi-flexible type.

It seems pretty generally agreed that pronation of the heel is the first deformity which must be corrected. Prevention or correction of reflection of the forefoot in standing and walking is the next factor to be considered. If the compensatory supination of the forefoot is marked, it must be given attention.

The majority of cases of flat feet will respond to treatment by some simple and inexpensive alterations to the shoe previously described. A Thomas heel is applied with a raise on the inner border of the heel of from  $\frac{3}{16}$  to  $\frac{3}{8}$  inches. It may be necessary to add a similar raise to the outer border of the sole to correct the compensatory supination of the forefoot. Exercises and contrast foot baths are, of course, recommended. In early and



very acute cases the longitudinal arch should be supported with a felt pad. The foot and ankle may be strapped with the foot held in some inversion; weight bearing should be reduced as much as possible. Exercises begin as soon as soreness allows. It is to this type of flexible flat foot that the metal arch supports are particularly harmful. They chafe and cause calluses of the foot. Instead of strengthening the foot they cause more atrophy. They may give relief for a short time, but the foot then becomes more painful than before.

Some individuals, however, will not respond to the treatment outlined above. Particularly is this true of an obese man who has to be on his feet almost constantly, such as a policeman. These do better with a rigid shank shoe and internal support of sponge rubber and leather constructed in such a way that the amount of elevation in the support may be changed as needed. A small metatarsal pad increases the efficiency of this support. Those individuals who have arthritic changes in the feet, or who have worn a rigid support for several years, also do better with this combination or a rigid support.

The spastic flat foot is more resistant and requires more drastic measures. In general, an attempt should be made to convert it into a flaccid flat foot and treat as such. Adhesive strappings at four-day intervals for two to three weeks will be sufficient to relax the muscular spasm in the milder one, but those of longer standing need manipulation under anesthesia, followed by casts for about three weeks. The foot is put up with the heel in supination, and the forefoot in pronation and adduction. Weight bearing is not allowed after removal of the cast until corrective shoes have been supplied. Physiotherapy should be instituted at once.

Flat feet in children are most often brought to the attention of the physician before the child is six years of age. Just why the arch does not become elevated in some children cannot always be determined by examination of the feet. They seldom complain of pain, but it is the deformity which causes the parents to seek advice. It is in these cases that built-up arch supports are particularly objectionable because of the fact that they cause the majority of the weight to be borne in the arch, for which the foot was not physiologically de-

signed by nature. These feet are flexible and respond nicely to wedging of the inner border of the heels. Occasionally it is necessary also to add an equal raise to the outer border of the sole. Corrective exercises should be begun as soon as the child is old enough to carry them out.

Metatarsalgia is pain in the region of the metatarsal heads and usually may be elicited on the dorsal or plantar aspect of the foot. It may or may not be accompanied by pain and disturbed mechanism of the longitudinal arch. Mild attacks may be cured by contrast foot baths, rest and strapping, but some form of support is usually needed. Small sponge rubber or felt pads placed just posterior to the metatarsal heads give relief in many cases. The accurate placing of the pad is of utmost importance. More resistant cases require a metatarsal bar or anterior heel. The bar is about  $\frac{1}{4}$  inch thick,  $\frac{1}{2}$  inch wide, is made of sole leather and is best put in the split sole if the shoe is so designed as to allow it. Several varieties of anterior heels have been designed, but, like the bar, all work on the principle of transferring weight farther posterior on the metatarsals.

Hallus valgus, or bunion, is another painful foot condition caused by dislocation of the first metatarso-phalangeal joint. This may be due to shoes which are too short or with heels too high. The fallen arch which is often associated with bunion probably causes an irritation of the nerves and a spasm of the short flexors of the toes. This with the spasm of the transverse head of the adductor hallucis tends to cause a gradual dislocation of the first metatarso-phalangeal joint. Removing the bursa or callus over it may give some temporary relief, but certainly does not cure the bunion. The extent of the surgical procedure naturally depends upon the severity of the deformity. In milder cases, removal of the exostosis on the medial side of the first metatarsal sometimes is sufficient. In more severe or longer standing cases, a wedge osteotomy of the first metatarsal is done from the medial side after the exostosis has been removed. Contracture of the conjoined tendon is remedied by tenotomy at its attachments to the base of the first phalanx on the lateral side. The toe is splinted for about three weeks in the corrected position. A metatarsal bar should be worn until

no pain remains. Lateral bunions seldom require more than removal of the exostosis.

Pes cavus or high arches give even more trouble than a low arch. They bear weight at only two points, the ball and heel. The plantar fascia is drawn very tight and the midtarsal joints are forced upward. Associated with this condition are usually found hammer toes and plantar warts or callosities. There is also tenderness in the heel and ball of the foot with many painful corns over the toes. These feet are very bad for both walking and bearing weight. Later the anterior arch gives way and there is metatarsalgia with cramping of the muscles of the feet. The feet are shiny and atrophic. Conservative treatment begins with a low, broad heeled shoe made of soft leather. A metatarsal bar is applied which tends to cause flexion of the toes. Exercises and hot soaks followed by alcohol massages give considerable relief. The toes should be manipulated downward and the foot brought into extension while the toes are bent down. Curling the toes down over the edge of a board or a stair-step while bearing weight is of some benefit. A small metatarsal pad is sometimes added to the inside of the shoes. Surgical treatment consists of cutting the plantar fascia from its posterior attachment to the os calcis and applying a cast with the foot in marked dorsiflexion to obliterate the arch as much as possible. It may be necessary to cut the tendons of the short toe flexors.

If the hammer toes do not respond to manipulation, surgery is needed. Tenotomy of the flexor tendon, lengthening of the extensor tendon, and arthrodesis of the proximal interphalangeal joints is the procedure of choice.

March foot is a fracture of one of the middle metatarsals which occurs in a weak foot and is not caused by trauma. Swelling and tenderness are localized over the fracture. These fractures may be easily overlooked in routine x-rays. Poor circulation and brittle bones in a weak foot are predisposing factors. Excess callus may lead to a mistaken diagnosis of sarcoma and amputation of the foot. The treatment of choice is absolute rest. Since

this cannot usually be obtained, the foot is strapped with a felt pad support.

Heel pain on the posterior aspect is occasionally seen in boys between 9 and 14 years of age. Exercise causes pain, redness and swelling of the heel. This condition is due to an irritation of the growth center of the calcaneal metaphysis owing to its severe muscular exertion applied through the Achilles tendon upon the apophysis of the heel. X-rays are diagnostic. Treatment is complete rest in a cast in severe cases; going barefoot is simplest in moderate ones; in others, raised heel, limited activity, removal of shoe counter, and diathermy will suffice.

Tenderness on the posterior part of the heel may also be due to a bursitis. There is pain, redness, tenderness and swelling. The bursitis is due to pressure on the heel by the shoe counter, and is relieved by removal of the counter. Pain on the plantar aspect of the heel is most commonly due to a bursitis or calcaneal spur. Surgical removal of the spur should be done only after conservative measures fail, because the spur often recurs, larger and more painful than before. Conservative treatment of these two conditions begins with sponge rubber heel pads or nest depressions in the shoe. X-ray or diathermy usually cure the bursitis.

With a little effort, physicians should treat the majority of feet successfully. Their training certainly should give them a better understanding of the principles involved than that possessed by agencies who now do a majority of the work. The study of feet is not uninteresting, and affords a means of relieving much suffering. Physicians doing this type of work need not develop a reputation of being a "corn doctor."

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(Address all communications to Box 1018, Jacksonville)



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**BASIC SCIENCE BOARD  
APPOINTED**

The members of the State Board of Examiners in the Basic Sciences for Florida have been appointed by the Governor. The Board met the latter part of September at the University of Florida, in Gainesville, to elect a chairman and a secretary. The membership of the Board is as follows:

Mark Wirth Emmel, D. V. M., Chairman, Professor of Veterinary Science, University of Florida.

John Ferguson Conn, Ph. D., Secretary, Professor of Chemistry, Stetson University.

Ezda May Deviney, M. S., Ph. D., Professor of Zoology, Florida State College for Women.

Jay F. W. Pearson, M. S., Ph. D., Professor of Zoology, Miami University.

Donald D. Bode, M. S., Ph. D., Professor of Chemistry, Tampa University.

This Board is qualified to give examinations in anatomy, bacteriology, chemistry, pathology, and physiology. The first examination of the State Board of Examiners in the Basic Sciences will be held November 4, 1939, in Gainesville. An abstract of the law may be found on page 630 of the June, 1939, Florida Medical Journal.

**SCHEDULE OF SESSIONS, AND REFERENCE COMMITTEES FOR HOUSE OF DELEGATES AT 1940 ANNUAL CONVENTION**

The steady growth of the State Medical Association is evidenced by the increasing number of doctors who have attended the annual conventions in recent years and the enthusiasm portrayed. The percentage of members of the Association who are attending the annual conventions and the medical district meetings is increasing rapidly. Adequate facilities for entertaining at larger meetings, the increased representation in the House of Delegates, additional floor space for technical exhibits, meetings of special groups and scheduling of sessions all present a problem at present, which did not exist at smaller meetings.

In order that all phases of the annual convention might have equal consideration, President Leigh F. Robinson appointed Dr. Gerry R. Holden to meet with various officials and groups and make a special study of the present system and to recommend to the Executive Committee changes that would make possible a more efficient schedule throughout the sessions of the annual convention. Doctor Holden met with the Executive Committee at Lakeland, September 27 and an entire evening was devoted to discussing the recommendations offered. Since the scientific sessions occupy a major part of the time, Dr. Walter C. Jones, chairman of the Association's Committee on Scientific Work, was invited to attend the meeting. One of the first considerations was to provide for more essayists during the scientific sessions and also, as far as possible, to have the scientific sessions continue without interruptions. In the past, very often a scientific session has been adjourned in the middle of a forenoon or an afternoon, definitely cutting off discussions, and the confusion of adjourning and reconvening had a tendency to retard the value of scientific sessions. A schedule was, therefore, adopted by the Executive Committee for the 1940 convention, which will provide for twenty papers. Four scientific assemblies will be listed, with five papers in each. This will allow more doctors on the program and also will allow each scientific session to go, uninterrupted, through the presentation of five papers, with their discussions.

Special groups having meetings during the convention will be allotted Monday forenoon for their meetings and programs. There will be no meetings scheduled to conflict with those of the special groups from 9 a. m. to 1:30 p. m. on Monday. These special groups have very interesting and valuable sessions and make a real contribution at annual conventions. Time was, therefore, allotted to these special groups so that other members and guests of the Association could attend without there being a conflict between sessions. Since the State Association does not have sections for specialties, the special groups take their place. These special group meetings are well attended and the programs are very interesting. At present, there are eight special groups, comprised of members of the State Association, which are featured on the program at state conventions: Radiology, Pediatrics, Railway Surgeons, Internists, Dermatology, Surgical Congress, Ophthalmology and Otolaryngology, and Industrial Surgeons.

The House of Delegates is scheduled to meet from 1:30 to 4:30 p. m. on Monday and will not conflict with the special group meetings, as heretofore. The State Association's regular program will start at 4:30 p. m. on Monday, with the first general session. At this session the secretary-treasurer and editor of the Journal will read his annual report. The address of the Association's president will then be presented. The Association's guest speaker will deliver his address Tuesday evening at 8:30, after the Association dinner.

The second meeting of the House of Delegates is scheduled for 4:30 p. m., Tuesday. This second meeting of the House of Delegates will be more important than in previous years. The committee reports and the resolutions read at the first meeting of the House of Delegates and referred to reference committees will be received at the second meeting of the House of Delegates, with recommendations by the chairmen of the reference committees affected. The recommendation of Doctor Holden for the appointment of three reference committees was approved by the Executive Committee at its last meeting. Reference committee number 1, on Health and Education, is to be composed of the chairmen of the following Association standing commit-

tees: Scientific Work, Postgraduate Course, Cancer Control, Venereal Disease Control, Tuberculosis and Health, Maternal Welfare, Child Health, and Necrology. Reference committee number 2, on Public Policy, will be composed of the following standing committee chairmen of the Association: Medical Economics, Legislation, Education and Hospitals, Public Relations, Inter-Relationship, State Institutions, Woman's Auxiliary, and Industrial Council. Reference committee number 3, on Finance, will be composed of the Association's treasurer, all members of the Executive Committee, the chairman of the Council and the chairman of the Past Presidents. By referring to the page listing officers and standing committees, the names of the doctors who are to serve on the reference committees may be found, as their names are listed as chairmen of the committees named in the above listing. The Executive Committee and those who have studied the question of reference committees feel that the work of the House of Delegates will be much more efficiently handled. When a committee report or a resolution is read at the first meeting of the House of Delegates, it will be referred immediately to a reference committee. Sometime between the first and second meetings of the House of Delegates, the reference committees will hold meetings, at which members of the House of Delegates and other members of the Association are privileged to sit in and to take part in discussions. This will undoubtedly emphasize the importance of committee reports, give a better opportunity for discussion and eliminate from the first meeting of the House of Delegates long discussions which have proved to be wearisome and ineffective. The Executive Committee and your members who have studied the changes to be tried at the 1940 convention hope to receive the hearty cooperation of the entire membership and will be pleased to have suggestions and constructive criticisms, in order that proceedings of our annual convention may be efficient, interesting and effective.

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#### MEDICAL DISTRICT MEETINGS

Ocala (B) .....Oct. 26  
Sanford (E) .....Nov. 9

ANNUAL MEETING OF THE FLORIDA  
EAST COAST MEDICAL ASSOCIATION

The scientific committee has arranged the following program to be rendered at the next meeting of the Association at Ponte Vedra, November 10 and 11.

C. Larimore Perry, M. D., Miami: "Differential Diagnosis and Treatment of Vulvar Granuloma Inguinale"; Claude Anderson, M. D., Orlando: "Intrathoracic Goitre" or "Adenomata of the Thyroid"; I. M. Hay, M. D., Melbourne: "Endometriosis"; Eugene L. Jewett, M. D., Orlando: "Fractures of the Femur"; J. C. Nowling, M. D., West Palm Beach: "Acute Meningitis Caused by Influenza Bacillus"; James J. Nugent, M. D., Miami: "Pyelonephritis—Recent Improvements in Treatment"; "Management of Chest Tumors" (by invitation): Louie Limbaugh, M. D., internist; Raymond King, M. D., bronchoscopist; W. McL. Shaw, M. D., roentgenologist; Kenneth Morris, M. D., surgeon.

The discussors of these papers will be announced later. The program committee feels very proud of the caliber of papers to be offered at this meeting. As a special feature, Dr. Frank K. Boland of Atlanta will be guest speaker.

All members of the Florida Medical Association are cordially invited to attend this meeting at Ponte Vedra, November 10 and 11. It is scheduled for the week of the annual Georgia-Florida football game and reservations should be made early. For further information, address Dr. E. C. Swift, 614 Greenleaf Building, Jacksonville, chairman of the Program Committee.

## MEDICAL DISTRICT MEETING—C

Palatka, September 14

The third annual meeting of the Northeast Medical District was held at Palatka, Thursday afternoon, at 2:30, September 14, with headquarters at the Coca-Cola Club Room. There was a total registration of 72, of which number 54 were Association members (from this district, 44); 2 were visitors; and 16 were ladies. The names of the ladies who registered will be found on page 206 of this Journal.

Dr. George M. Green, senior councilor, called the general session to order, as scheduled. The address of welcome was given by

Dr. E. W. Ford, president of the Putnam County Medical Society. The following state officials and representatives made brief addresses: Dr. Leigh F. Robinson, president; Dr. Shaler Richardson, secretary-treasurer-editor; Dr. Herman Watson, chairman of the Council; Dr. T. Z. Cason, and Dr. G. C. Tillman, Medical Postgraduate Course Committee; Dr. Walter C. Jones, Scientific Work Committee and Committee on Publication; Dr. Luther W. Holloway, School Health Program; Dr. Joseph S. Stewart, Executive Committee; Dr. J. Ralston Wells, first vice-president and Public Relations Committee; Dr. Thomas H. Bates, second vice-president. Four past presidents of the State Association were present: Drs. Gerry R. Holden, Edward Jelks, W. Henry Spiers and H. Marshall Taylor. Dr. Ludo von Meysenbug, on behalf of the Volusia County Medical Society, extended an invitation for the 1940 meeting to be held in Daytona Beach. The invitation was unanimously accepted.

After a ten-minute intermission, Dr. R. B. McIver, junior councilor, called the scientific session to order. The following papers were presented and the time for discussion was extended as a large number of those present took part: "Emergency Procedures in General Practice" (*illustrated*), Dr. Reddin Britt, St. Augustine; "Spontaneous Massive Collapse of the Lung," Dr. Joseph H. Rutter, Daytona Beach; "Traumatic Surgery in a Small Hospital," Dr. G. M. Zeagler, Palatka; and "The Smith-Peterson Nail in Fractures of the Neck of the Femur" (*illustrated*), Dr. Frank G. Slaughter, Jacksonville.

At 7 p. m. a barbecue picnic was held on the Coca-Cola grounds where the ladies and guests joined the doctors at a real feast. Temporary tables had been constructed, with an overhead lighting system, and these tables were loaded with all the trimmings usual to a barbecue. The barbecue, itself, was donated by Dr. Z. Brantley who thus fulfilled his promise of last year when he extended the invitation to hold this medical district meeting at Palatka.

## REGISTRATION—DISTRICT C

*Officers:* George M. Green, Daytona Beach, Senior Councilor; R. B. McIver, Jacksonville, Junior Councilor; Stewart Thompson, Jacksonville, Managing Director.



*Bunnell:* D. T. Rankin. *Cocoa:* W. C. Page. *Crescent City:* E. W. Ford, B. E. Kane. *Daytona Beach:* J. H. Rutter, Ludo von Meysenbug, J. R. Wells. *Ft. Lauderdale:* L. F. Robinson. *Gainesville:* G. C. Tillman. *Grandin:* Z. Brantley

*Jacksonville:* D. M. Baldwin, J. L. Boone, Alan Brown, T. Z. Cason, D. N. Cone, S. E. Driskell, Karl Hanson, G. R. Holden, L. W. Holloway, Edward Jelks, Louie Limbaugh, T. H. Lipscomb, J. G. Lyerly, W. H. McCullagh, S. R. Norris, J. N. Patterson, Shaler Richardson, F. G. Slaughter, L. M. Sompayrac, H. Marshall Taylor, E. H. Teeter, Joseph Weinreb, J. F. Wilson.

*Lake City:* L. J. Arnold, Jr., T. H. Bates. *Lakeland:* Herman Watson. *Miami:* Walter C. Jones, J. S. Stewart. *New Smyrna Beach:* W. C. Chowning. *Orlando:* W. H. Spiers. *Palatka:* Emory Bell, A. P. Gurganious, H. A. Johnson, C. M. Knight, G. M. Zeagler. *St. Augustine:* Reddin Britt, C. C. Grace, R. D. Harris, G. W. Potter, A. C. Walkup, H. E. White. *Tampa:* A. M. Bidwell.

Visitors—*Palatka:* John T. Hosey.

## MEDICAL DISTRICT MEETING—D

Lakeland, September 28

The third annual meeting of the Southwest Medical District was held at Lakeland, Thursday afternoon at 2:30, September 28, with headquarters at the Yacht and Country Club. There was a total registration of 128, of which number 91 were Association members (from this district, 75); 5 were visitors; and 32 were ladies. The names of the ladies who registered will be found on page 208 of this Journal.

The meeting was called to order by Dr. Herman Watson, senior councilor, the address of welcome being given by Dr. John F. Wilson, president of the Polk County Medical Society. The following state officers made brief addresses: Dr. Leigh F. Robinson, president and Dr. Shaler Richardson, secretary-treasurer and editor of the Journal. Dr. George M. Green, councilor of the sixth district, substituting for Doctor Watson, read the report of the chairman of the Council. The following chairmen of the State Association's standing committees made brief reports: Dr. Gilbert S. Osincup for the Executive Committee and Dr. Walter C. Jones for the Committee on Scientific Work. Dr. W. W. George substituted for Dr. T. Z. Cason for the Committee on Medical Postgraduate Course. Two of the past presidents in this district were present and recognized: Dr. W. P. Adamson and Dr. O. O. Feaster. Dr. W. Henry Spiers, a past president from District E, was present and recognized. Dr. A. B. McCreary, State Health Officer, made a brief address.

On behalf of the Pinellas County Medical

Society, the doctors from Dunedin extended an invitation to have the fourth annual meeting of the Southwest Medical District held in their city in 1940. The invitation was endorsed by Dr. W. C. McConnell and, on motion, was unanimously accepted.

After a short recess, the scientific session was called to order by Dr. W. C. McConnell, the junior councilor. The following papers were presented: "Prevention and Control of Venereal Diseases," Dr. G. F. Highsmith, Arcadia; "Pituitary Gland Dysfunction, with Case Report," D. F. H. Murphey, St. Petersburg; "Osteomyelitis," Charles L. Farrington, St. Petersburg; "Low Blood Pressure and Pregnancy," E. Bryant Woods, Tampa.

The doctors and guests were royally entertained at Lakeland by Dr. Herman Watson, senior councilor and the local Committee on Arrangements, Dr. T. H. Roberts, chairman, Dr. J. L. Hargrove and Dr. T. C. Keramidas. The Yacht and Country Club was a delightful place to hold a medical meeting and everything was done to care for the comfort and pleasure of those present. After the scientific session the ladies joined the doctors for cocktails, followed by the dinner. There was a total of 91 served in the beautiful dining room overlooking the lake. Dr. Herman Watson was in charge of the program and made a short talk, followed by Dr. T. H. Roberts. The principal address was given by State Senator S. L. Holland. At the close of the meeting Doctor Watson urged a full attendance at the 1940 medical district meeting which will be held at Dunedin.

## REGISTRATION—DISTRICT D

*Officers:* Herman Watson, Lakeland, Senior Councilor; W. C. McConnell, St. Petersburg, Junior Councilor; Stewart Thompson, Jacksonville, Managing Director.

*Arcadia:* G. F. Highsmith. *Auburndale:* T. G. Simmons. *Bartow:* J. L. Hargrove, R. L. Hughes, W. F. Peacock, C. H. Wilson. *Bradenton:* M. M. Harrison, C. W. Larrabee. *Brevster:* R. L. Tolle. *Clearwater:* R. H. Center, Robbins Nettles. *Davenport:* P. W. Besenbruch. *Daytona Beach:* George M. Green. *Dunedin:* J. A. Mease, Jr., H. E. Winchester. *Ft. Lauderdale:* Milton N. Camp, Leigh F. Robinson. *Ft. Meade:* G. H. Carefoot, S. A. Lindsey. *Ft. Pierce:* A. M. Sample. *Jacksonville:* Louie Limbaugh, A. B. McCreary, Shaler Richardson.

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Stewart. *Orlando*: C. D. Hoffmann, L. C. Ingram, A. C. Kirk, Gilbert Osincup, W. H. Spiers.

*Plant City*: J. W. Alsobrook, Edgar Austin, T. C. Maguire. *St. Petersburg*: Arnold S. Anderson, Charles L. Farrington, O. O. Feaster, John A. Herring, D. F. H. Murphey, W. H. Pickett, Carl A. Williams. *Sarasota*: T. W. Taylor, C. B. Wilson. *Sebring*: H. V. Weems. *Tampa*: W. P. Adamson, C. A. Andrews, J. R. Boling, L. F. Carlton, James L. Estes, A. S. Gilmer, Stephen Gyland, A. R. Knauf, B. W. Lowry, Frank C. Metzger, John T. Moore, David R. Murphey, Harold G. Nix, H. Mason Smith, N. L. Spengler, Glenn Stayer, J. W. Taylor, R. S. Torbett, E. B. Woods. *West Palm Beach*: W. W. George. *Winter Haven*: Waldo Horton, T. C. Keramidas, R. H. Mooty.

Visitors—*Lakeland*: Sam J. Clark. *St. Petersburg*: R. J. Needles. *Tampa*: J. C. Griffin, A. W. Woodburne.

## BIRTHS, MARRIAGES AND DEATHS

### BIRTHS

Dr. and Mrs. A. E. Drexel of Daytona Beach announce the birth of a son, Todd Edward, on August 15, 1939.

Dr. and Mrs. H. B. Lott of Tampa announce the birth of a daughter on August 24.

Dr. and Mrs. John Henry Thomas of Gainesville announce the birth of a daughter, Penelope, on September 4 in the Alachua County Hospital.

### MARRIAGES

Dr. James Nelson Patterson and Miss Viola Townsend Davis, both of Jacksonville, were married Sept. 30.

### DEATHS

Dr. Paul Eskeberg of Miami died on September 3 in Chicago, following an illness of several months.

## STATE NEWS ITEMS

Dr. E. J. Melville of St. Petersburg spent the summer in Ireland and Scotland, during which time he visited clinics. Mrs. Melville accompanied him on the trip abroad.

\* \* \*

Dr. S. Allen Clark of Lakeland now has a new associate, Dr. Sam J. Clark, who recently completed the residency in obstetrics and gynecology at the Emory University division of Grady Hospital, Atlanta.

\* \* \*

The following Florida doctors registered at the meeting of the American Congress on Obstetrics and Gynecology, held in Cleveland, in September: T. S. Field, S. R. Norris, Ferdinand Richards, I. J. Strumpf, Jacksonville; R. S. Howell, R. W. Jack, J. D. Milton, Homer Pearson, J. R. Perdue, R. T. Spicer, M. C. Wilson, Miami; C. J. Collins, C. D. Hoffmann, Orlando; R. G. Nelson, A. L. Stone, Tampa; G. W. Heath, West Palm Beach; B. F. Hart, Winter Park.

Dr. A. E. Drexel of Daytona Beach moved recently into his new, modernistic building.

\* \* \*

Dr. W. J. Williams recently opened offices in Cassia. Doctor Williams was formerly located at DeLand.

\* \* \*

Dr. J. Ralston Wells of Daytona Beach attended Doctor Finney's clinic in Johns Hopkins Hospital the first two weeks in October.

\* \* \*

Dr. J. E. Harris of Sarasota spent the month of September doing postgraduate work in cardiology at the Massachusetts General Hospital, Boston.

\* \* \*

Dr. and Mrs. J. C. Davis of Quincy spent three weeks of the late summer in the North Carolina mountains.

\* \* \*

Dr. Orville Nelson of Bay Pines spent six weeks in Minnesota where he attended clinics at Mayo's and the University Hospital.

\* \* \*

Dr. Russell B. Carson opened offices recently at 620 Sweet Building, Ft. Lauderdale. Doctor Carson was formerly located in Orlando. He will limit his practice to urology.

\* \* \*

Dr. J. H. Chiles, formerly of Holopaw, is now located at 715 North Hyer Street, Orlando.

\* \* \*

Dr. T. F. McDaniel of Sanford returned recently from Buffalo, New York, where he took postgraduate work.

\* \* \*

Drs. Donald W. Smith and Perry D. Melvin of Miami spent the month of September in Philadelphia, doing postgraduate study.

\* \* \*

Dr. T. H. Bates of Lake City spent his vacation in August as acting Division Surgeon of the 82nd Division, U. S. Army, at Ft. Moultrie, S. C.

\* \* \*

Dr. Waldo Horton of Winter Haven spent the month of August at Charity Hospital, New Orleans, doing special work in dermatology and syphilology.

\* \* \*

Dr. R. B. Harkness of Lake City was honored recently by receiving Fellowship in the American College of Surgeons.

Dr. Joseph B. Pomerance of Miami Beach spent a month this summer touring the United States and Canada, visiting clinics and hospitals.

\* \* \*

Dr. W. C. Page of Cocoa spent a month, the latter part of the summer, visiting clinics in large centers of New York, Washington, D. C., and Virginia. Mrs. Page accompanied him.

\* \* \*

Dr. Maurice E. Heck of Miami spent ten days visiting clinics in Chicago and ten days at Mayo Clinic, Rochester, during the late summer. Doctor Heck was away for six weeks, touring a number of states.

\* \* \*

Dr. Ralph E. Russell of Ocala is spending several weeks in Chicago, taking special work in ophthalmology at the Cook County Graduate School of Medicine. Before his return to Florida, he will attend the clinics of the American College of Surgeons in Philadelphia.

\* \* \*

Dr. Samuel Aronovitz of Miami spent several weeks visiting clinics and hospitals in New York. The major part of his time was spent at Mount Sinai Hospital.

\* \* \*

Dr. Hollis C. Ingram of Orlando in September took a special course in nose and throat work at Cook County Graduate School of Medicine in Chicago. He was accompanied on the trip by Mrs. Ingram.

\* \* \*

Dr. James I. Thorne of Miami was recently in New York, Philadelphia and Baltimore on endocrinology work.

\* \* \*

Dr. Harrison G. Palmer of St. Petersburg spent the latter part of August visiting clinics and vacationing in the North Carolina mountains. Mrs. Palmer accompanied him.

\* \* \*

Dr. Hugh E. Parsons of Tampa recently opened an office at 509 Maas Building. Doctor Parsons will confine his practice to ophthalmology.

\* \* \*

Dr. Jos. H. Lucinian and family of Miami spent the month of September in the North. Doctor Lucinian visited clinics in Baltimore and Boston.

The 25th annual meeting of the Radiological Society of North America will be held at the Atlanta Biltmore Hotel in Atlanta, Georgia, beginning December 10 and concluding December 15.

This is the first time a national society of this size has held its annual meeting in the southeast. All members of the Florida Medical Association are invited to attend this meeting as guests, there being no registration fee required.

\* \* \*

Dr. Thomas E. Buckman of Jacksonville has been appointed medical director of the King Edward Industrial Nursery which was opened on September 26. Dr. S. I. Kemp will assist Doctor Buckman in his duties at this institution, which is said to be the Nation's first industrial nursery.

---

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## COMPONENT COUNTY SOCIETIES

### DADE COUNTY MEDICAL SOCIETY

The regular meeting of the Dade County Medical Society was held Tuesday evening, September 5, at the Ingraham Building. Two scientific papers constituted the program, as follows:

"Thyroglossal Duct Cysts and Fistulae" (with lantern slides)—E. H. Adkins, Miami; discussion opened by C. Larimore Perry and Geo. D. Lilly.

"Technical Requirements as Related to the Growth of Medicine"—Iva C. Youmans, Miami; discussion opened by Buist Litterer and John Snyder.

\* \* \*

### DUVAL COUNTY MEDICAL SOCIETY

The first meeting, since adjournment this spring, was held by the Duval County Medical Society on the evening of October 3, in the library of the State Board of Health Building, Jacksonville. Dr. L. S. Laffitte presented a paper on "Quinidine in Some Manifestations of Heart Disease" which was discussed by Drs. T. Z. Cason and Louie M. Limbaugh. A business meeting was held following the scientific session.



## ORANGE COUNTY MEDICAL SOCIETY

The annual barbecue of the Orange County Medical Society was held on the evening of August 31 at the Dudsread Country Club, Orlando. As usual, this was a festive occasion attended by many out-of-town guests.

\* \* \*

## PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Dr. Claude L. Carter entertained the Pasco-Hernando-Citrus County Medical Society at the Orange Hotel in Inverness, Thursday evening, September 14. A full course dinner was enjoyed followed by a meeting at the hotel.

Dr. J. S. Turberville of Century, President-elect of the Florida Medical Association, was invited to attend a joint meeting of the Society and the Kiwanis Club in Brooksville, Thursday evening, Sept. 26, and speak on the plan of organizing a bureau or society for medical relief.

A letter from Dr. Stewart G. Thompson, Managing Director of the State Association, was read urging all members to attend the annual district meeting in Ocala, October 26.

Dr. Edward Henry Brown of Dade City was elected to membership in the society.

Pneumonia treatment was discussed by members present, and other clinical case reports were given.

Dr. Bradshaw invited the Society to meet with him in October.

Those present were: Drs. J. T. Bradshaw, C. L. Carter, G. R. Creekmore, S. C. Harvard, W. W. Jones, W. B. Moon, D. B. Manley, and W. H. Walters.

\* \* \*

## PINELLAS COUNTY MEDICAL SOCIETY

Dr. N. W. Gable, Jr., of St. Petersburg was principal speaker at a meeting of the Pinellas County Medical Society held at the Chatterbox on the evening of September 1. His subject was "Ethmoiditis."

The Society held a dinner and dance for its members and their ladies at Wally's on September 15.

\* \* \*

## PUTNAM COUNTY MEDICAL SOCIETY

One hundred per cent of dues for 1939 have been received from the Putnam County Medical Society. Officers of this society are: president, Edward W. Ford, Crescent City; secretary-treasurer, C. M. Knight, Palatka.

## ABSTRACT DEPARTMENT

*Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.*

## Effect of Avitaminosis A on Human Blood

Picture, ABBOTT, O. D., AHMANN, C. F., and OVERSTREET, M. R., Gainesville, *Am. J. Physiol.* **126**: 254 (June), 1939.

Abbott and his co-workers made differential leukocyte counts on the blood of 157 individuals whose diets and symptoms indicated a vitamin A deficiency. The blood picture of all the subjects showed several variations from normal hematologic standards. Among these were a decrease in total leukocytes and polymorphonuclears, an increase in juveniles and large lymphocytes, and degeneration, especially of the granulocytes. This blood picture is similar to that of rats fed a diet deficient in vitamin A and, as in the case of the rats, the administration of large amounts of vitamin A brought about a gradual improvement in symptoms and in a few weeks the differential count was within the normal range. From this work it was concluded that the differential leukocyte count is of diagnostic value in vitamin A deficiency in man.

Tuberculosis Survey in Florida, LOGIE, ARTHUR J., Jacksonville, *Am. Rev. Tuberc.* **39**: 408-418 (Mar.), 1939.

During the period from June 1937 to June 1938, 12,866 persons were given the tuberculin test and the positive reactors were x-rayed. These persons were from selected groups composed of indigent contacts and suspected cases of tuberculosis, and senior high school and freshmen college students from ten scattered counties throughout the state.

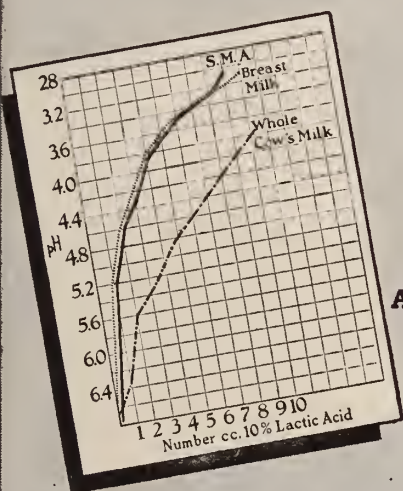
The Powers rapid x-ray unit with paper film in rolls was used and pictures were taken one month following the tests. All tests were done with P. P. D. tuberculin in two strengths.

Of the total tested 32.7 per cent reacted. In the age group over 5 years the ratio of the incidence of Negro reactors to white was 1.4 to 1 although the death rate is three and one-half times that of the white. In the group under 5 years, 49.2 per cent of the children reacted, an exceedingly high incidence prob-

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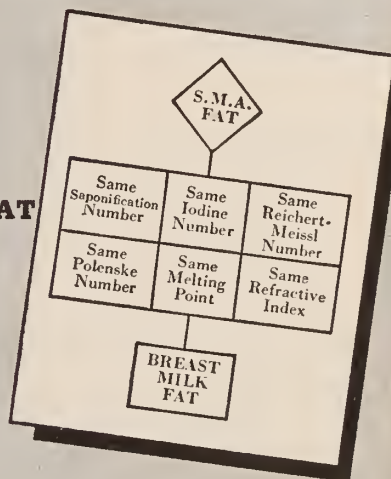
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ably accounted for by the fact that all had been in contact with tuberculosis at home. Notwithstanding the fact that a relatively large proportion of those tested were reported as contacts, the percentage for all age groups over 5 years was considerably lower than those reported in a recent similar survey of Lee County, Ala.

The percentage of reactors to first strength P. P. D. was 7.5 and to second strength, 27.1. Of those reacting to first strength 30.3 per cent showed definite x-ray lesions and to second strength, 20.8 per cent. In the age groups, that of 25 and over showed the greatest percentage of demonstrable x-ray lesions. Of the cases reported as contacts 32.4 per cent showed x-ray lesions, while in the non-contact group the incidence was 19.3 per cent.

**A Review of the Results from the Employment of Malaria Therapy in the Treatment of Neurosyphilis in the Florida State Hospital, BOYD, MARK F.; STRATMAN-THOMAS, W. K.; KITCHEN, S. F.; and KUPPER, W. H., Tallahassee, *Am. J. Psychiat.* 94: 1099-1114 (Mar.) 1938.**

Two hundred ten patients suffering from neurosyphilis, admitted to the Florida State Hospital in the past five years, were inoculated with malaria in addition to routine chemotherapy. All but 20 of these contracted malaria. A statistical, comparative study of these cases reveals a number of interesting facts.

In those receiving malaria therapy 31.6 per cent showed remissions, 23.2 per cent were improved, 19.5 per cent were unimproved and 25.8 per cent died; whereas those having only chemotherapy showed respectively, 20 per cent, 10 per cent, 25 per cent and 45 per cent.

The quartan type of malaria produced the most effective results and there was no significant difference between natural and artificial introduction of the parasite.

The number of *severe* paroxysms seems the important factor in producing remissions and lower mortality, rather than merely the number of paroxysms.

Persons under 30 appeared to acquire greater benefit from malaria therapy than those above this age.

Patients presenting only organic signs have done better than those with mental involvement, and of those mentally involved the agitated type have shown greater improvement than the depressive.

## ADVERTISERS' NOTES

### LIGHT WEIGHT FLOOR STAND

In reply to popular demand, American Optical Company announces its Lightweight Floor Stand is again available in standard colors to match its various units. It is suitable for use with the Phorometer, for prism reading, etc., but is not recommended for heavy instruments such as the Phoropter. For the latter, the 521B Floor Stand is recommended.

### WHAT EVERY WOMAN DOESN'T KNOW—HOW TO GIVE COD LIVER OIL

Some authorities recommend that cod liver oil be given in the morning and at bedtime when the stomach is empty, while others prefer to give it after meals in order not to retard gastric secretion. If the mother will place the very young baby on her lap and hold the child's mouth open by gently pressing the cheeks together between her thumb and fingers while she administers the oil, all of it will be taken. The infant soon becomes accustomed to taking the oil without having its mouth held open. It is most important that the mother administer the oil in a matter-of-fact manner, without apology or expression of sympathy.

If given cold, cod liver oil has little taste, for the cold tends to paralyze momentarily the gustatory nerves. As any "taste" is largely a metallic one from the silver or silverplated spoon (particularly if the plating is worn), a glass spoon has an advantage.

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### SQUIBB'S NEW LABORATORY

Establishment of a new laboratory for the study of filterable virus diseases, in the treatment and prevention of which science is believed to be at the threshold of an important advance, is announced by the Squibb Biological Laboratories.

Dr. Raymond C. Parker, biologist of the Rockefeller Institute for Medical Research, and for many years an associate of Dr. Alexis Carrel, has been appointed to head the laboratory, which will operate as a unit of the Biological Division of E. R. Squibb and Sons at New Brunswick, N. J. The new building is a continuation of a program of expansion which began in the Fall of 1938 with the dedication to pure science of the \$750,000 laboratory of the Squibb Institute for Medical Research.

"Enlargement of the Company's biological facilities was undertaken because rapid development in the knowledge of filterable viruses has made it probable that our ability to prevent and control infection from these sources will have a rapid expansion in the immediate future," Dr. John F. Anderson, director of the Biological Laboratories, explained.

Among the common diseases caused by filterable viruses, Dr. Anderson pointed out, are smallpox, rabies, equine encephalitis, measles, chicken pox, poliomyelitis, and the common cold. No specific product for the prevention of four of these diseases—the common cold, poliomyelitis, chicken pox, and measles—is now available.

More than 500 scientists from ten nations witnessed the first demonstration of the new virus laboratory during a tour of the Squibb Institute and the Biological Laboratories on September 6 and 7. The group, composed of delegates to the Third International Congress for Microbiology, which met in New York City, September 2 to 9, also inspected the Rockefeller Institute for Medical Research at Princeton on Wednesday, September 6.





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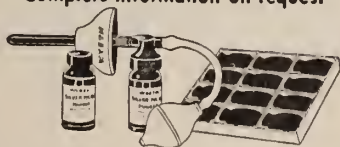
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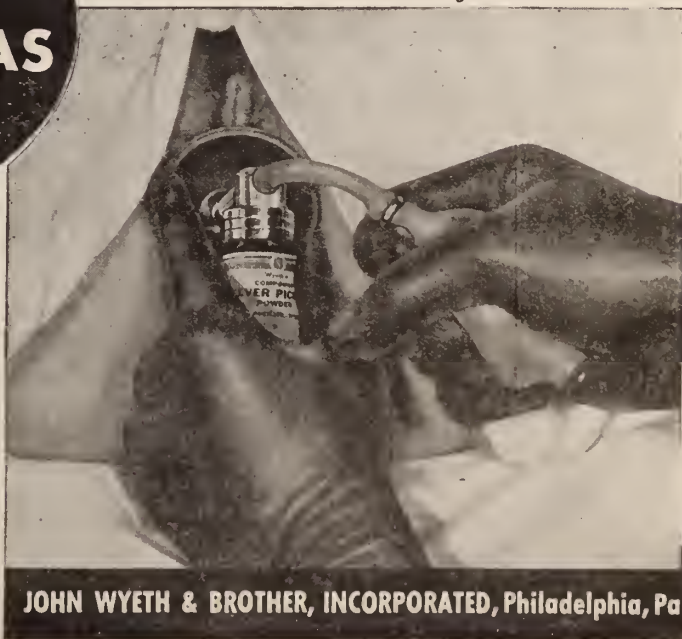
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## OUTLINE OF FALL PROGRAM

Carolyn F. Ingram, President

Now that most of our vacations are over and we are settling back into our regular routine of work, each Auxiliary is urged to take its task seriously.

The membership should study the program which was published in the July *Journal* and make every effort to complete the work as outlined by the Advisory Committee and the Program Chairman. Our National Officers have asked us to give major consideration to Public Relations, Education, Hygeia and Legislation.

Below are the places and dates of meeting for our last two District Conferences; also the chairmen in charge. A short business session will be held and some form of entertainment provided. You are cordially invited to attend as many of these Conferences as possible.

CITY	DATE	CHAIRMAN
Ocala (B)	Oct. 26	Mrs. G. C. Tillman, Gainesville
Sanford (E)	Nov. 9	Mrs. Frank Gray, Orlando

## AUXILIARY DISTRICT CONFERENCES

PALATKA (C), SEPTEMBER 14

On September 14, the Northeast District of the Florida Medical Association held a meeting in Palatka, with 16 ladies present. This was a "red letter" day for the ladies, as it was their first district meeting, this being the first year the State has been districted for the Woman's Auxiliary.

## CONTINUOUS ACCEPTANCE BY THE COUNCIL ON FOODS OF THE AMERICAN MEDICAL ASSOCIATION

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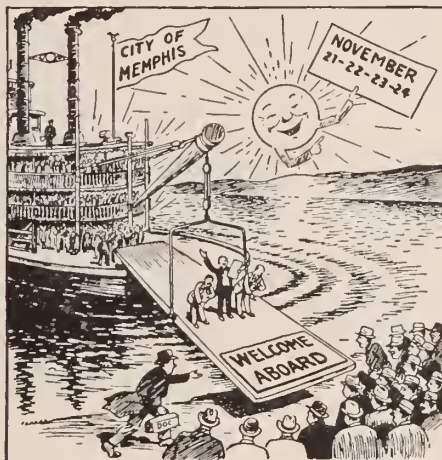
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**W**ELCOME to MEMPHIS to the outstanding medical meeting of the year—the annual meeting of the Southern Medical Association, November 21-24. In the nine general clinical sessions, the nineteen sections, the three independent medical societies meeting conjointly and the scientific and technical exhibits, every phase of medicine and surgery will be covered—the last word in modern, practical, scientific medicine and surgery. Addresses and papers will be given by distinguished physicians not only from the South but from all over the United States.

**R**EGARDLESS of what any physician may be interested in, regardless of how general or how limited his interest, there will be at Memphis a program to challenge that interest and make it worth-while for him to attend.

**A**LL MEMBERS of State and County medical societies in the South are cordially invited to attend. And all members of state and county medical societies in the South should be and can be members of the Southern Medical Association. The annual dues of \$4.00 include the Southern Medical Journal—the equal of any, better than many.

**SOUTHERN MEDICAL ASSOCIATION**

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While the men were holding their scientific session, the ladies were entertained at the home of Dr. and Mrs. Allen Gurganious. The wives of the other Palatka physicians assisted Mrs. Gurganious.

Mrs. E. W. Veal, district chairman, presided and introduced the officers of the State Society who were present: Mrs. L. C. Ingram, president; Mrs. C. E. Royce, historian; Mrs. S. M. Copeland, legislation; and Mrs. J. A. Pines, Press and Publicity.

Mrs. Veal in her opening remarks briefly reviewed the work of the Woman's Auxiliary since its organization in Florida thirteen years ago. While it has been a big task to bring the work to its present state, Mrs. Veal feels that it has now reached the place where those who pioneered the work can soon step aside and younger women will gladly carry on.

The program for the coming year was read by Mrs. Royce. Mrs. Ingram followed, commenting on the different charges which she hopes to see carried out 100 per cent if possible, especially emphasizing: health institute, school essays, Hygeia subscriptions, Jane Todd Crawford Memorial and special studies on current legislative measures.

Mrs. Copeland also stressed the importance of the legislative department and our duties, as members, of so unique a society as that of the Woman's Auxiliary.

Following the business session an informal hour was enjoyed with bridge games and a visit to the Ravine Gardens; after which Mrs. Gurganious and her assisting hostesses served light refreshments from a table beautifully decorated with flowers and tall white candles in silver candelabra.

#### REGISTRATION—DISTRICT C

*Ft. Lauderdale:* Miss Betty Robinson. *Grandin:* Mrs. James W. Brantley. *Jacksonville:* Mrs. S. M. Copeland, Mrs. Thomas H. Lipscomb, Mrs. C. E. Royce, Mrs. E. W. Veal. *Orlando:* Mrs. L. C. Ingram, Mrs. J. A. Pines. *Palatka:* Mrs. F. Emory Bell, Mrs. Allen Gurganious, Kate K. Johnson, Mrs. Harlow Merryday, Mrs. John H. Randolph, Emily R. Taylor, Mrs. G. M. Zeagler. *St. Augustine:* Mrs. G. W. Potter.

#### LAKELAND (D), SEPTEMBER 28

The attendance and enthusiasm for the annual district Auxiliary meetings is steadily increasing. There were 32 ladies registered at this Lakeland meeting, with 7 counties represented. A very interesting program was held at the Yacht and Country Club at 2:30 p. m. Mrs. R. H. Mooty, vice-president of the

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701 Clay St., WINTER PARK. Phone 275-R
- ★ MRS. L. L. GARBUTT  
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Polk County Auxiliary, presided. Mrs. L. C. Ingram of Orlando, president of the State Auxiliary, was the first speaker and gave a very fine address, covering the plans for activities during the year. Mrs. Ingram read a letter from Mrs. Rollo Packard, president of the National Auxiliary.

The entertainment was planned by Mrs. R. L. Cline of Lakeland, chairman of the local Entertainment Committee, assisted by Mrs. J. R. Boulware, Jr., and Mrs. John F. Wilson. A motorcade included visits to the Carpenter's Home and the Florida Southern College. Punch was served at the Yacht Club just preceding the motorcade and the ladies were entertained at tea in the home of Mrs. R. L. Cline. They then joined the doctors at the Yacht Club for cocktails and dinner, following which Senator Holland made the principal address.

#### REGISTRATION—DISTRICT D

*Dunedin:* Mrs. H. E. Winchester. *Ft. Meade:* Mrs. G. H. Carefoot. *Lakeland:* Mrs. J. W. Annis, Mrs. Paul Bird, Mrs. Joe M. Bosworth, Mrs. James R. Boulware, Jr., Mrs. S. A. Clark, Mrs. Sam Clark, Jr., Mrs. R. L. Cline, Mrs. G. C. Freeman, Mrs. John Jares, Miss Bertha McIntosh, Mrs. W. E. Meneray, Mrs. L. B. Nicholson, Miss Lucille Seed, Mrs. J. W. Vaughn, Mrs. Edgar Watson, Mrs. W. A. Weed, Mrs. John F. Wilson. *Lake Wales:* Mrs. A. Y. Pennington, Mrs. B. Y. Pennington. *Miami:* Mrs. Walter Jones, Mrs. Joe Stewart. *Orlando:* Mrs. L. C. Ingram. *St. Petersburg:* Mrs. Charles L. Farrington, Mrs. John A. Herring, Mrs. W. C. McConnell, Mrs. Robert J. Needles, Mrs. J. E. Skehan. *Tampa:* Mrs. Stephen Gyland, Mrs. David R. Murphey, Jr. *Winter Haven:* Mrs. R. H. Mooty.

#### BOOKS RECEIVED

*Acknowledgment of books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review, as expedient.*

**CANNED FOOD REFERENCE MANUAL.** By AMERICAN CAN COMPANY. A valuable little book, issued under the Seal of Acceptance of the Council on Foods of the American Medical Association. It is an amplification of two previous texts issued by this Company (*Facts About Commercially Canned Foods*, 1936, and *Nutritive Aspects of Canned Foods*, 1937). The Federal Food, Drug, and Cosmetic Act is incorporated in this volume, besides which there are sections on "Canning Technology," "Canned Foods in Human Nutrition," "Public Health Aspects of Canned Foods," "The Past Twenty Years of Canning Research," and "Useful Facts About Commercially Canned Foods." The appendix contains 21 tables, including those on composition of some commercially canned foods, proximate composition of some unseasoned and unsweetened canned foods, reported vitamin values and pH. ranges of some commercially canned foods, Federal canned fruit and vegetable grading stations, recent canned food production figures, inorganic components of common foods, and vitamin values of some foods. Fabrikoid, Pp. 242, with 41 illustrations. The Haddon Craftsmen, Inc.

**EPIDEMIC ENCEPHALITIS: THIRD REPORT.** By MATHESON COMMISSION, WILLARD C. RAPPLEYE, Chairman. The Matheson Commission was established through the generosity of Dr. William J. Matheson in the spring of 1927. The work of the first two years consisted in collecting the published data on the epidemiology, etiology, and treatment of epidemic encephalitis. The results of this study were published in the *First Report* in 1929. A second, shorter report of a similar nature was published in 1932. The *Third Report* has been prepared on much the same lines as the first two reports. The long continued follow-up of a large number of patients suffering from this disease or other conditions closely simulating it has provided a volume of clinical evidence and experience that has proved of greatest value in differential diagnosis and in the appraisal of methods of treatment. The bibliography has been carried on from the beginning of 1930 through the first half of 1937, and many of the more important references in the second half of 1937 and the first half of 1938 have been included. In the laboratory program several viruses have been isolated and vaccines have been produced and tried in treatment. Fabrikoid, Pp. 493. Price \$3.00. New York: Columbia University Press.

**POPULATION, RACE AND EUGENICS.** By MORRIS SIEGEL, M. D. In two sections: first, "Positive Eugenics" in which there are chapters on Population and Eugenics, Etiology, Constructive Recommendations, Racial Theories in Relation to Eugenics, and Rational Marriage; second—"Restrictive Eugenics," which deals with the Feeble-Minded, Mental Disorders, Epilepsy, Restrictive Measures, and General Conclusions. Cloth. Pp. 206. Price \$3.00. Published by author, Hamilton, Ontario, 1939.



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## COMPONENT SOCIETIES BY DISTRICTS — FLORIDA MEDICAL ASSOCIATION

Districts	COUNTY SOCIETIES	PRESIDENT	SECRETARY	MEETING DATE	COUNCILOR and Counties Not Included in First Column	Members	
						Total	Paid
Northwest District (A) Marianna July 20, 1939	Bay	Donald S. Fraser, M.D. Panama City	William C. Roberts, M.D. Panama City		A-1-'40 Carol C. Webb, M.D. Pensacola	12	100%
	Escambia	L. C. Fisher, Jr., M.D. 816 N. Palafox St. Pensacola	J. M. Hoffman, M.D. 1221 E. DeSoto St. Pensacola	2nd Tuesday 8:00 P. M.		44	38
	Walton-Okaloosa	A. G. Williams, M.D. Lakewood	R. B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P. M.		6	100%
	Washington-Holmes	W. D. Ramsey, M.D. Noma	L. H. Paul, M.D. Bonifay		Santa Rosa	8	7
	Franklin-Gulf	Chapman Dykes, M.D. Carrabelle	A. L. Ward, M.D. Port St. Joe	3rd Thursday	A-2-'41 B. A. Wilkinson, M.D. Tallahassee	6	100%
	Jackson	C. J. Price, M.D. Alford	R. N. Joyner, M.D. Marianna	2nd Tuesday 7:30 P. M.		13	12
North Central District (B) Ocala October 26, 1939	Leon-Gadsden-Liberty-Wakulla-Jefferson	W. W. Massey, M.D. 204 N. Madison St. Quincy	B. A. Wilkinson, M.D. Telephone Bldg. Tallahassee	Quarterly 3:00 P. M.	Calhoun	39	35
	Columbia	W. M. Ives, M.D. 132 N. Marion St. Lake City	Harry S. Howell, M.D. Blanche Hotel Annex Lake City	1st Monday 7:30 P. M.	B-3-'41 W. S. Nichols, M.D. Lake City	21	16
	Madison	E. Long, M.D. Madison	A. F. Harrison, M.D. Madison			3	2
	Taylor	Geo. H. Warren, M.D. Perry	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P. M.	Baker-Dixie-Hamilton-Lafayette-Suwannee	8	6
	Alachua	J. E. Maines, Jr., M.D. 433 E. Main St. N. Gainesville	J. Maxey Dell, Jr., M.D. 333 W. Main St., S. Gainesville	2nd Friday 7:30 P. M.	B-4-'40 James L. Strange, M.D. McIntosh	29	24
	Marion	Carl S. Lytle, M.D. Dunnellon	R. C. Cumming, M.D. Commercial Bank Bldg. Ocala	3rd Thursday 12:30 P. M.		23	100%
N. E. District (C) Palatka September 14, 1939	Pasco-Hernando-Citrus	Claude L. Carter, M.D. Inverness	G. R. Creekmore, M.D. Brooksville	2nd Thursday 7:00 P. M.		15	100%
	Sumter		A. B. Albritton, M.D. (Acting Secretary) Wildwood	2nd Tuesday	Bradford-Gilchrist-Levy-Union	3	2
	Duval	Thomas E. Buckman, M.D. 1022 Park St. Jacksonville	Lauren M. Sompayrac, M.D. 459 St. James Bldg. Jacksonville	1st Tuesday 8:15 P. M.	C-5-'41 R. B. McIver, M.D. Jacksonville	174	172
	St. Johns	R. D. Harris, M.D. St. Augustine	G. Walter Potter, M.D. East Coast Hospital St. Augustine	3rd Tuesday 8:30 P. M.	Clay-Nassau	10	100%
	Putnam	Edward W. Ford, M.D. Crescent City	C. M. Knight, M.D. Palatka	2nd Tuesday in Feb., April, June, Aug., Oct., Dec. 7:00 P. M.	C-6-'40 George M. Green, M.D. Daytona Beach	11	100%
	Volusia	Maximilian Stern, M.D. Box 5098 Daytona Beach	R. L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P. M.	Flagler	41	40
Southwest District (D) Lakeland September 28, 1939	Hillsborough	J. W. Alsobrook, M.D. 120 N. Collins St. Plant City	James S. Grable, M. D. 811 Citizens Bank Bldg. Tampa	1st Tuesday 8:00 P. M.	D-7-'41 W. C. McConnell, M.D. St. Petersburg	112	98
	Manatee	S. G. Hollingsworth, M.D. 451 12th St. Bradenton	M. M. Harrison, M.D. Professional Bldg. Bradenton	3rd Tuesday 7:00 P. M.		14	100%
	Pinellas	E. C. MacCordy, M.D. 366 First Federal Bldg. St. Petersburg	W. C. McConnell, M.D. 1001 First Federal Bldg. St. Petersburg	1st and 3rd Fridays 6:30 P. M.		93	100%
	Sarasota	T. W. Taylor, M.D. Professional Bldg. Sarasota	Stanley T. Martin, M.D. Sarasota	2nd Tuesday 8:30 P. M.		17	14
	DeSoto-Hardee-Highlands-Charlotte-Glades	Ben D. Spears, M.D. Wauchula	Howard V. Weems, M.D. 22 Oak St. Sebring	2nd Tuesday 8:00 P. M.	D-8-40 Herman Watson, M.D. Lakeland	20	100%
	Lee	C. Gordon Merrick, M.D. 26 Leon Bldg. Fort Myers	H. L. Allan, M.D. 312 Fythian Bldg. Fort Myers	3rd Friday 7:30 P. M.		14	12
South Central District (E) Sanford November 9, 1939	Polk	John F. Wilson, Jr., M.D. Box 254 Lakeland	J. R. Boulware, Jr., M.D. P. O. Box 367 Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P. M.	Collier-Hendry	61	100%
	Brevard	W. J. Creel, M.D. Eau Gallie	I. K. Hicks, M.D. Melbourne	3rd Tuesday	E-9-'40 W. C. Page, M.D. Cocoa	11	9
	Lake	W. G. DeVane, M.D. Groveland	Oliver Emerson, M.D. Tavares	1st Thursday 12:30 P. M.		18	15
	Orange	C. D. Hoffmann, M.D. 120 E. Robinson St. Orlando	Fred Mathers, M.D. Box 53 Orlando	3rd Wednesday 8:30 P. M.		80	79
	Seminole	Thomas F. McDaniel, M.D. Seminole County Bank Bldg. Sanford	Douglas G. Scott, M.D. 212 N. Park Ave. Sanford	2nd Monday 7:00 P. M.	Osceola	12	100%
	St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D. Box 942 Stuart	Adrian M. Sample, M.D. Ft. Pierce	3rd Thursday 8:00 P. M.	E-10-'41 A. M. Sample, M.D. Ft. Pierce	17	100%
S. E. District (F) West Palm Beach October 12, 1939	Broward	R. L. Elliston, M.D. 814 Sweet Bldg. Ft. Lauderdale	Oliver C. Brown, M.D. 915 Sweet Bldg. Fort Lauderdale	4th Wednesday 8:00 P. M.	F-11-'40 Lloyd J. Netto, M.D. West Palm Beach	34	100%
	Palm Beach	Gaylord Lewis, M.D. 916 Harvey Bldg. W. Palm Beach	C. Jennings Derrick, M.D. Box 574 W. Palm Beach	4th Monday 8:00 P. M.		58	100%
	Dade	M. Jay Flipse, M.D. 305 Huntington Bldg. Miami	Franz Stewart, M.D. 1105 Huntington Bldg. Miami	1st Tuesday 8:30 P. M.	F-12-'41 Kenneth Phillips, M.D. Miami	299	273
	Monroe	Harry C. Galey, M.D. 532 Fleming St. Key West	W. R. Warren, M.D. 511 Eaton St. Key West	1st Sunday 9:00 P. M.		4	100%

STATE AND SECTIONAL MEETINGS

SOCIETY	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association.....	Leigh F. Robinson, Ft. Lauderdale	Shaler Richardson, Jacksonville....	Tampa, 1940
Florida Medical Districts:			
A—Northwest .....	B. A. Wilkinson, Tallahassee....	Stewart Thompson, Jacksonville....	Pensacola, 1940
B—North Central .....	J. L. Strange, McIntosh.....	" " "	Ocala, Oct. 26, 1939
C—Northeast .....	Robt. B. McIver, Jacksonville....	" " "	Daytona Beach, 1940
D—Southwest .....	W. C. McConnell, St. Petersburg.	" " "	Dunedin, 1940
E—South Central .....	W. C. Page, Cocoa.....	" " "	Sanford, Nov. 9, 1939
F—Southeast .....	Lloyd J. Netto, West Palm Beach.	" " "	West Palm Beach, Oct. 12, 1939
Alabama Medical Association.....	M. S. Davie, Dothan.....	D. L. Cannon, Montgomery.....	Birmingham, April 16-18, 1940
Georgia, Medical Assn. of.....	W. H. Myers, Savannah.....	E. D. Shanks, Atlanta.....	Savannah, April 23-26, 1940
Florida—			
State Dental Association.....	R. P. Taylor, Jacksonville.....	E. C. Lunsford, Miami.....	West Palm Beach, Oct. 12-14, 1939
Soc. of Derm. and Syph.....	Elmo D. French, Miami.....	Lauren M. Sompayrac, Jacksonville	Jacksonville, Nov. 1939
East Coast Medical Association.	Frederick J. Waas, Jacksonville..	A. J. Logie, Jacksonville.....	Jacksonville, Nov. 10-11, 1939
State Hospital Association.....	J. H. Therrell, Chattahoochee....	Mr. Fred M. Walker, Jacksonville..	Mississippi, March, 1940
Assn. of Industrial Surgeons.....	C. E. Tumlin, Miami.....	A. M. Bidwell, Tampa.....	Tampa, 1940
Internists' Society.....	Norval M. Marr, St. Petersburg..	Kenneth Phillips, Miami.....	Tampa, 1940
Medical Postgraduate Course...	Turner Z. Cason, Jacksonville....	Chairman	Jacksonville, 1940
Soc. of Ophthal. & Otol.....	S. B. Forbes, Tampa.....	Temporary Chairman.....	Tampa, 1940
State Nurses Association.....	Mrs. Inez Nelson, Orlando.....	Mrs. Phyllis Leonard, St. Augustine	Lakeland, Nov. 6-8, 1939
Pediatric Society .....	Warren W. Quillian, Coral Gables	G. N. Leonard, Miami Beach.....	Tampa, 1940
Pharmaceutical Association.....	Mr. S. F. Harris, Jacksonville..	Mr. A. W. Morrison, Miami.....	Tampa, May, 1940
Public Health Association.....	Mr. S. D. Macready, W. P. Beach	E. M. L'Engle, Jacksonville.....	Jacksonville, Dec. 7-9, 1939
Radiological Society .....	H. B. McEuen, Jacksonville.....	J. N. Moore, Ocala.....	Tampa, 1940
Railway Surgeons' Association...	H. D. Clark, Ft. Pierce.....	W. C. Page, Cocoa.....	Tampa, 1940
Tuberculosis & Health Assn....	Mr. G. E. Therry, W. Palm Beach.	Mrs. May Pyncheon, Jacksonville..	Spring, 1940
Chattahoochee Valley Med. Assn..	M. Y. Dabney, Birmingham.....	Frank K. Boland, Atlanta.....	Albany, Ga., July 9-11, 1940
Gulf Coast Clinical Society.....	J. H. Dodson, Mobile.....	C. C. Rouse, Mobile.....	Mobile, Oct. 26-27, 1939
Internat. Assn. Milk Sanitarians..	Mr. V. M. Ehlers, Austin, Texas..	Mr. C. Sidney Leete, Albany, N. Y.	Jacksonville, Oct. 25-27, 1939
Southeastern Derm. Assn.....	Jack Jones, Atlanta.....	Howard Hailey, Atlanta.....	Atlanta, Ga., Sept. 1, 1940
Southeastern Surgical Congress...	R. L. Sanders, Memphis.....	B. T. Beasley, Atlanta.....	Birmingham, Mar. 11-13, 1940
Southern Medical Association.....	W. E. Vest, Huntington, W. Va.	Mr. C. P. Loranz, Birmingham....	Memphis, Nov. 21-24, 1939
Winnipeg River Medical Society..	T. H. Bates, Lake City.....	H. S. Howell, Lake City.....	

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\*Frazer, J. G.: The Golden Bough, vol. 1, New York, Macmillan & Co., 1923



It is ironical that the practice of attempting to cure rickets by holding the child in the cleft of an ash tree was associated with the rising of the sun, the light of which we now know is in itself one of Nature's specifics.

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Florida Medical Association, Tampa, April 29, 30, and May 1, 1940  
Southern Medical Association, Memphis, November 21-24, 1939

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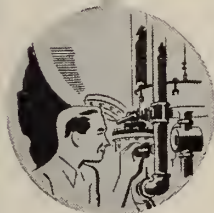
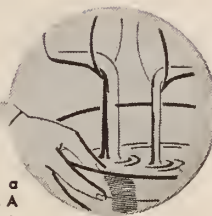


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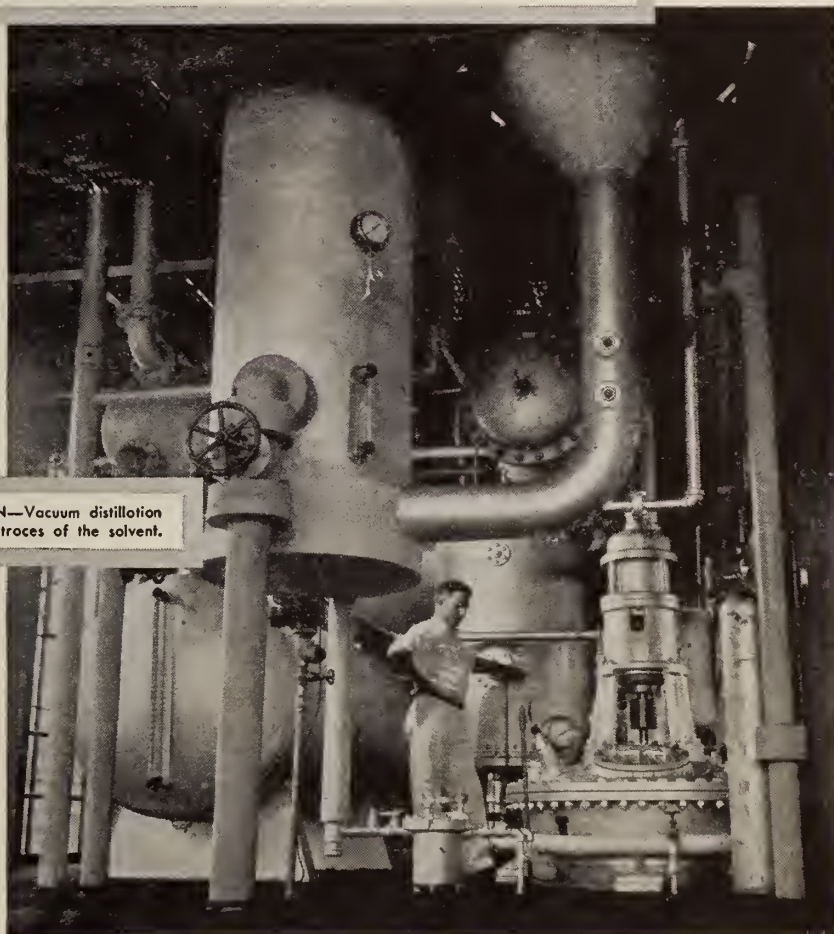


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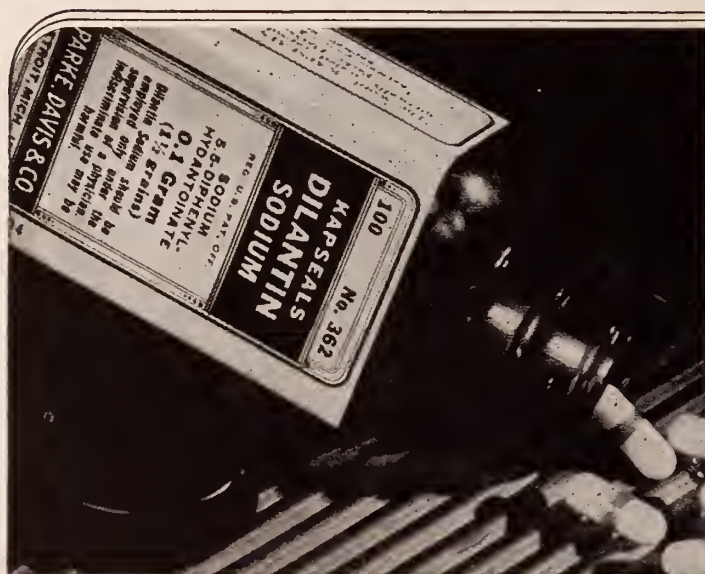
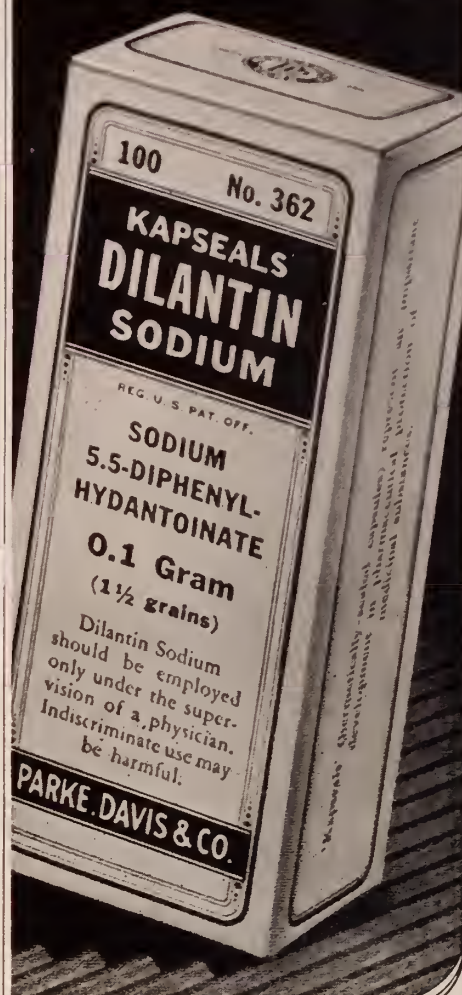
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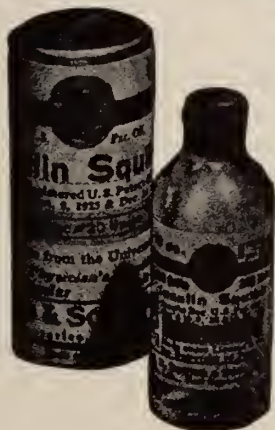


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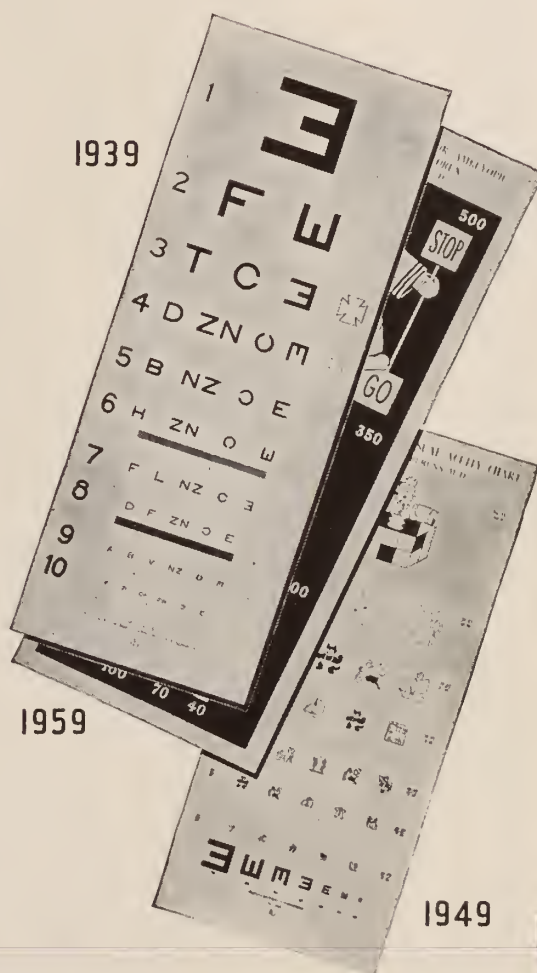
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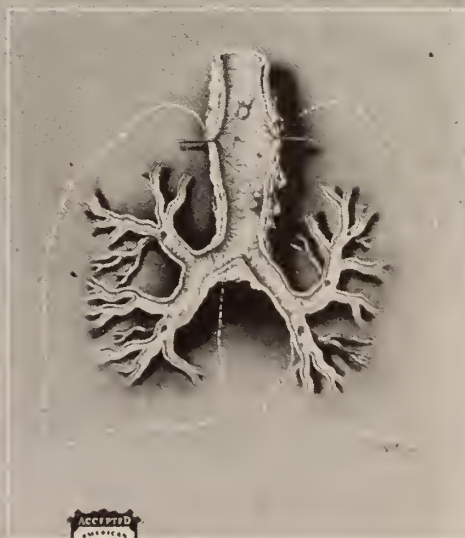
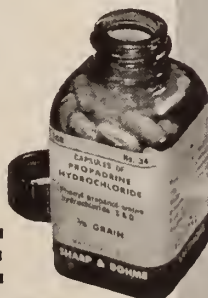
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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

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Jacksonville, Florida, November, 1939

Number 5

## EUGENIC STERILIZATION

A. T. COBB, M. D.  
Gainesville

Eugenics is the science of human betterment. It is concerned with being well born and with all those social agencies which may impair, mentally or physically, the racial qualities of future generations. Eugenic sterilization is that phase of eugenics which is concerned with the prevention of offspring of the now socially inadequate through surgical or other means. We are not, at this time, primarily concerned with sterilization incident to treatment of organic disease or for contraceptive purposes. It is a highly controversial subject and one that reaches not only into the fields of psychiatry and sociology but into medicine and surgery, religion and government, and, indeed, into every phase of human relations. It is of vital importance to every one and particularly to the members of our profession to whom those concerned with the shaping of our future policies will, rightfully and justly, turn for advice and guidance.

Human sterilization laws began with the State of Indiana in 1907 and now 28 states have such laws. Ten more have recently attempted to get laws through their legislatures. They vary in character; some are voluntary, some compulsory, some punitive, and some are a combination. Twenty thousand people have now been sterilized for eugenic purposes. It would seem that this is no longer in the experimental stage but is an established means of combatting the increase of mentally undesirables. The State of Florida has no such law and, insofar as I am aware, no concerted moves have been made toward securing one. For this reason we must necessarily rely upon reports from those states in which extensive studies have been made. Some laws have been declared unconstitutional. Others have been upheld, as that of Virginia by the United States Supreme Court with the terse state-

ment that "three generations of imbeciles are enough."

The surgical procedures generally used and accepted as the most satisfactory are bilateral vasectomy or salpingectomy according to sex involved. With a reasonable degree of medical certainty, sterilization is thus produced. Irradiation is not often used because of the young age of most of the patients and the resulting artificial menopause. Some have advocated resection of a portion of the fallopian tubes only; some, resection with extraperitonealization of the remaining segments; some advocate abdominal, some vaginal, and some an inguinal extraperitoneal route. High amputation of the cervix possibly produces sterilization and this procedure has been advocated. Electrical coagulation of the uterine portion of the tubes intra-abdominally and through the uterine cavity has been done. Simple ligation of the tubes is very likely to fail to produce permanent results as, indeed, it would seem that even complete salpingectomy may sometimes fail. It should be borne in mind that the possibility exists, and it has occurred, of a hydrosalpinx or other trouble if a portion of the tube remains. So far as I can determine, no definite effect has been proved on the function of the ovary, menstruation or libido of those in whom complete salpingectomy has been done.

To many, even our more highly educated and our legislators, the mentioning of sterilization seems to bring immediately to mind the idea of a mutilating operation, castration and injury to the person involved. Such ignorance and prejudice has materially impeded advancement along these lines. It is, of course, not necessary to explain to a group of this type that such procedures as outlined above will not nor are they intended to unsex any person or even to hinder in any way his or her capacity for satisfying sexual desires. The general health, mental or physical, is not disturbed and the only difference is that the individual has undergone a surgical procedure, the result of which is the loss of power to procreate. The mortality and morbidity of

vasectomy should be nil; that of salpingectomy almost so.

Among arguments against sterilization is that it will serve to increase delinquency, encourage promiscuity, and spread venereal infections. However plausible it might seem at first, this has not been borne out by facts. It is based upon the assumption that the fear of pregnancy will prevent antisocial conduct. To those of us who are most familiar with the reactions of the mentally ill and particularly the feeble-minded, it is evident that with their lack of judgment, foresight and self control they may not be expected to use prudence or even to curtail their activities because of a fear of pregnancy. Even before sterilization the feeble-minded girl is by no means overly burdened with inhibitions against sexual indulgence. All studies seem to indicate that if there is any difference it is toward the side of morality.

With what would seem poor justification, some have claimed that sterilization would possibly prevent the birth of some genius or future leader. Most of those in whom such procedure would be indicated would come from ranks of unskilled labor, unemployed and dependents. The question of heredity and environment in their respective roles in the etiology of mental conditions is still unsettled and still extensively debated. The more our knowledge as to the causes of mental conditions advances the less we can blame on heredity but statistics still indicate that a great group of them may be so placed. Adding to that the impressions that one apparently must form when dealing with relatives of these patients, it would seem that even with our limited knowledge we can safely predict that many of the offspring of such patients will be epileptic, feeble-minded, or in some manner neuropathically tainted. Should one be normal his or her chances of growing to normalcy in such an unhealthy environment would at best be rather slim. The whole idea gives one the impression of a farmer planting his whole field in weeds with the hope that some will grow to be beautiful flowers.

The irresponsible and frequently very definitely neuropathically tainted have not attempted to limit their families and as an average there are five children while in a control group there are only two. Families that send a feeble-minded child into a state insti-

tution average twice as many as those who send one to the university. They are not mentally capable of managing themselves or their affairs with ordinary prudence and large families, poverty, ignorance, maybe immorality and unnecessary suffering, are the result. They are certain to contribute more than their share to the ranks of our future inadequates. They will continue to exercise their right of franchise, all too frequently ill-advisedly and possibly too easily influenced by other than the best in ideals of government. It would seem that self preservation for the nation as a whole is more justifiable than for the individual alone, and that to permit these people to continue to propagate their kind is a terrible price to pay for the so-called "personal freedom" of a few.

Most of the legal objections have been that the wilful prohibiting of natural propagation of the race is contrary to the best interest of the public; that compulsory sterilization invades the right of an individual as a free citizen; that it constitutes "cruel and unusual punishment"; that sterilization of certain groups, as for example those admitted to a state institution, consists of "class legislation"; that it denies him or her the benefit of "due process of law"; that it interferes with "personal freedom." Any law enacted must care for these objections or will probably prove worthless. Soundly prepared, it must be conservatively administered. It must not state the actual procedure to be carried out as the surgeon may find himself forced by legal procedures to carry out operations that, under the existing circumstances, might not be best for his patient.

It is not the individuals within the state institutions that are causing such great concern as to future inadequates but the great throng out in the population at large. Sterilization laws should probably be of compulsory and voluntary nature and apply to both those within and those outside of institutions. With proper precautions, the operation should be permitted in general as well as in state-owned institutions. South Dakota requires that all feeble-minded be registered and they may not be married unless either they or their marital partners are first sterilized. As a matter of fact, compulsory procedures are not often necessary. Many patients and most of their relatives are usually willing to give the necessary



permission and are frequently happy that they are able to avail themselves of these protective means. We, ourselves, have frequent requests from parents or public officials that such operations be done. Under the circumstances we must refuse.

Only those of us connected with work of this type know of the thought and plans necessary before we are able to release one of our older patients, fully developed physically and sexually, but still a child in mind. It is always with a fear of disastrous consequences that we do so. Sterilization would render this process much less risky and permit us to release many whom we would not now dare. Others could then benefit by the training now denied them because of overcrowded conditions.

Over one-half of a million patients are within mental institutions in this country. Our own state has 5,100. Ninety-seven per cent are in governmentally owned institutions and consequently tax supported; 120,000 new patients are annually admitted. They are probably equalled by a like number that for various reasons will not be admitted. During the past ten years our general population has increased 9 per cent, while beds for mental patients have increased 36 per cent and still they are inadequate. There are 500,000 epileptics in our country. It is estimated that from one to two per cent of our population is feeble-minded. More beds are occupied and more patient days are spent by mental patients than all others combined. The mentally strong and healthy family is growing smaller; the undesirable is not. Twenty per cent of money spent for maintenance or one and one-half per cent of that spent for all purposes by state governments is spent for the care of the mentally ill. Mental diseases are increasing. The economic burden is tremendous and steadily growing worse.

Mass sterilization is not advocated. Eugenic sterilization is no panacea and might even be considered unscientific in that it fails to get at the cause. It will work slowly and in the end perhaps superficially, but it seems that, while we are waiting and searching for those causes, we might be doing that which is possible in an effort to stem a tide that is threatening the economic security and intellectual greatness of this great country of ours.

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*Florida Farm Colony.*

#### DISCUSSION

*Dr. J. C. Robertson, Chattahoochee:*

I have thoroughly enjoyed Doctor Cobb's paper, and he has so adequately covered the subject that I feel there is very little to be added.

I believe we can admit without question that much of mental defectiveness is directly inherited and that there is a close relationship between vice, crime, drunkenness, poverty, and feeble-mindedness.

Public indifference toward this situation is largely due to being accustomed to the acceptance of the burden of caring for these individuals, and crime, disease, men-



tal defectiveness, and degeneracy have been assumed by society to be necessary evils.

The time has come, however, when public attention is going to be more and more sharply focused on this problem. Daily in our newspapers we read of instances of sex crimes and attacks being made on women and children by degenerates and morons. These instances have occurred largely in the more populous northern areas, but the time is rapidly approaching when these occurrences are going to happen in our own state unless we take immediate steps to ward them off by every means in our power.

I agree with Doctor Cobb that the defective are highly prolific and it is said that the coming three-quarters of the next generation is being produced by the inferior one-quarter of this generation.

Segregation is becoming increasingly impractical as a solution, due to the rapidly increasing number and subsequent increasing cost which is becoming prohibitive. We cannot hold these individuals in an institution for a life time simply because they will probably have several defective children when they otherwise may make an adjustment. With our limited facilities we can only pass them on, realizing full well that we are adding to future society's burden in proportion to the number of offspring they have. In many instances the offspring is not wanted by the defective himself and lessens what little chance he may have had to get along himself.

Sterilization would seem to substantially reduce the incidence of defectives, vice, and degeneracy if adequately carried out for the next 50 years. Sterilization should not be advocated in doubtful, mild, or questionable forms of defectiveness, but is definitely indicated in the undoubted feeble-minded, whether manifest by criminality, imbecility, degeneracy, or certain forms of insanity. At the state hospital we are frequently asked by patients and by patients' families to carry out sterilization procedures, but are legally unable to furnish them and society this protection.

I certainly feel that immediate legislation should be enacted to care for this group who realize their predicament and ask voluntarily for help.

I also feel that a complete survey of the whole subject should be made in such states as already have this type of legislation, in order that we may make effective plans for this type of legislation in our own state in the immediate future.

Our medical association should take the lead and should contribute in every way possible to the advancement of such a program, both by informing the people and securing sponsors for such legislation in other organizations.

#### *Dr. T. Z. Cason, Jacksonville:*

Dr. Cobb's paper was an excellent one.

The reason we make so little progress in this connection is due to loose thinking and personal prejudices. The proper approach to the subject seems to me to be through the science of genetics. We have been talking loosely about the whole subject.

Doctor Cobb's statistics may be in error. It can be easily illustrated by the number of cases of tuberculosis reported. If you start a campaign you will soon find that there are many more cases than you suspected actually existed. I think the same thing is true about these cases.

It seems to me utterly foolish simply to talk about the cases we have, and I think the proper approach to the subject is through a study of genetics to determine scientifically those cases which are inherited.

These gentlemen have been talking primarily about mental diseases. There are a number of things. Diabetes is known to be inherited. If we are going to approach this problem, why not do it scientifically, rather than through our method of wishful thinking. Inaugurate marriage laws that will prohibit the marriage

of people where there are known diseases—producing deficiencies in the race or early deaths, and then sterilize the individuals in our institutions.

#### *Dr. George S. McClellan, Pompano:*

I wish to thank Doctor Cobb for this paper; it is very good.

The thing that impresses me the most is when and where we are going to make a start. Our grandfathers knew that no two morons or imbeciles ever produced a normal child. Yet morons are allowed to marry and reproduce and even imbeciles have become parents in Florida.

It is true that people of psychotic tendencies have produced normal children. But it is well known that morons, imbeciles, as well as those suffering from certain types of dementias, and manias never produce a normal child and if these unfortunates were examined by a board of psychiatrists a good many tragic births could be prevented by hygienic sterilization without taking any chances of sterilizing any one whose progeny would be of the slightest value to posterity.

A scientific study (probably by the same board) could then be made of the doubtful ones who were not sterilized and who produced children, to see what others of inferior mentalities had best have hygienic sterilization.

#### *Dr. Alan Brown, Jacksonville:*

I would like to ask Doctor Cobb what the situation is in the feeble-minded institutions, that is if he knows of any where sterilizations are being done with the consent of the parents or relatives at this time.

#### *Dr. A. T. Cobb (Concluding):*

I admitted at the beginning that this was a very highly controversial subject. We will have to get in a good bit of education, particularly of the lay people, in order that public opinion may be crystalized to such extent that such legislation if passed would be practical.

Doctor Cason's remarks as to marriage laws I think are very good. I mentioned one state which required that these people consent to sterilization. The great trouble along that line, as we see it, is that a lot of these feeble-minded girls are having children before getting married. Probably 4 per cent of our population are illegitimate children.

We have often thought of Doctor Brown's question, that is, sterilizing these people with the consent of relatives; but since it is an illegal operation and not indicated by organic disease we do not feel justified in laying ourselves open to considerable criticism or possible criminal prosecution should something go wrong.

We see a lot of these things and I would like to give you one illustration. This may be a little out of the usual, but still we do see such cases. A father came into the institution and asked that he be allowed to see his children. I asked if he wanted to see all seven of the children and he said he wanted to see all eight. A quick survey of the record failed to show eight, but seven. He merely said, "Oh! I thought the other one was here, too." The history shows that the maternal great grandmother was feeble-minded. How many deficient children she may have produced we do not know. But in this one family seven out of eight children had to be admitted to an institution. There was only one normal child in the group, and she was later found to be pregnant, supposedly by her own father. The father is illiterate and probably deficient. These seven children have cost the taxpayers of our state \$23,000.00 in maintenance, and should they live an average of 45 years they will have cost \$75,000.00.

I wish to thank the Association for the privilege of reading this paper, and those who have so kindly discussed it.

## THE MANAGEMENT OF INJURIES FROM AUTOMOBILE ACCIDENTS

E. B. HARDEE, M. D.

Vero Beach

The great decrease in morbidity and mortality from diseases has largely been offset by the appalling number of injuries from motor vehicle accidents and only once during the past five years has there been a decrease in deaths from automobile accidents in Florida.

In the United States in 1938 there were 95,000 deaths caused by accidental means and 9,200,000 individuals were disabled by injury.<sup>1</sup> Of this number 32,000 were traffic fatalities. This represents an economic loss of more than \$3,000,000 in the United States alone.

Florida comes into this picture with a mortality of 1,491 from all accidents, 624 of these being deaths from automobile accidents. Thus we have a rate of 44.5 per 100,000 population while the rate for the nation is only 30.6.

The mortality from automobile accidents has increased until it now is in the seventh place as the cause of death in this state. A great number of safety campaigns have been instituted by various political bodies and other organizations in an effort to decrease this, notable of which was the action of the American Medical Association at its annual session in Kansas City in 1936. A committee was appointed and authorized by the House of Delegates to study motor vehicle accidents and in its report the following facts were brought out:

The importance of this problem can be better comprehended when we realize that motor vehicle accidents are the principal cause of death in the age group of 5 to 64 and that, if the present rate of slaughter continues, one out of twenty persons in the U. S. will be injured or killed in a motor vehicle accident within the next five years. An even more startling prophecy is that unless some drastic means of combating traffic accidents is instituted, two out of every three children now living will be injured in a motor vehicle accident in his lifetime.

The year 1937 saw the decrease in the mortality for motor vehicle accidents throughout the United States, yet in Florida there were 57 more fatalities than in 1936.

It is a fact that in the relatively short life of the automobile there have been more fatalities attributed to them than there were in all

the wars that the United States has engaged in and, more serious than the immediate fatalities, are the seriously injured and disfigured persons who are handicapped and whose future is blighted through mental derangement as well as physical incapacity.

Accidents of serious nature are happening each day on every important highway in Florida and every country and village physician is called out on the highway to care for these injured. One of the most important points in the future outcome of any such injury is the immediate treatment given. Frequently victims with fractured cervical, thoracic and lumbar vertebrae are picked up by solicitous motorists, placed in a seated position in automobiles and transported to physicians' offices or hospitals. The same holds true in cases of fractures of the extremities.<sup>2</sup> The attendant's first thought is to lift the injured patient with his fractured back or extremity and carry him to a more comfortable place than the roadside. This is one of the worst things that can be done. Further injury to the cord is sustained and in the fractured extremity there is additional injury to the muscles, nerves and blood vessels, frequently compounding what otherwise would have been a closed fracture.

In a large percentage of injuries from automobile accidents we are dealing with fractures. It was not until the World War that the importance of the earliest possible fixation of broken bones was illustrated sufficiently to make this a medical maxim. This was brought about chiefly through the application of a Thomas knee-splint to fracture of the femur. We have in this country annually approximately 300,000 fractures to the extremities due to automobile accidents. The first aid given will in the vast majority of cases determine the amount of pain, the length of hospitalization and, to a great extent, whether the injured will be permanently crippled. These fractures should be fixed with the least possible trauma and left alone until the danger of producing further surgical shock has passed.

When we first see the victim of an automobile accident, there are two things that demand immediate attention: first, the control of hemorrhage and second the treatment for shock. Suffice it to say the external hemorrhage should be treated *per se*.

<sup>1</sup>Read before the Sixty-sixth Annual Meeting of the Florida Medical Association held at Daytona Beach, May 1, 2 and 3, 1939.



Naturally we are interested in finding out as quickly as possible the extent of injury and our examination must be thorough. We must, however, not lose sight of the fact that these injured persons are excited. Careful and frequent studies of the pulse, respiration and blood pressure together with a microscopic study of the urine give us a fair index to the general condition. As the excitement and shock abate, our examinations may be carried further. I have never been able to see the rationale of lifting a patient on a stretcher, transporting him to the operating room and subjecting him to fluoroscopic and radiographic studies while he is either excited or in shock. If he is excited, sedatives or opiates should be given. If he is in shock, external heat should be applied, epinephrine given, hypodermically and glucose intravenously.

The percentage of patients admitted to the Indian River Hospital, in coma from automobile accidents, has been relatively high. We were safe in assuming in practically every instance that there was traumatic injury. As would be expected, the mortality has been high in the comatose patients.<sup>3</sup> The serious prognostic signs are compound fracture of the skull, bleeding or drainage of cerebrospinal fluid from ear or nose, and surgical shock. In all of these cases there was abnormality of the pulse, respiration, blood pressure, or pupillary changes.

Very frequently at the site of an automobile accident and even after the injured has been brought into the hospital we will find one member of the party walking around insisting that there is nothing wrong with him and that we give our undivided attention to some minor laceration on some other member of the party. It is my routine practice to insist that every occupant of an automobile featuring in a collision or upset either sit or lie down until he can be moved by experienced ambulance attendants. By observing this rule we will in a great number of cases decrease the mortality and lessen the morbidity. We must never lose sight of the fact that these injured are excited and it is hours before we can get anything like an accurate description of the accident. Then, too, in most instances we are dealing with strangers. We know nothing of their physical condition or previous illnesses. It is very disconcerting to have one member of a party leave the hospital

and return to the wreck to be brought back within a few hours in a state of collapse because we accepted his statement that he was not injured. They should all be put to bed, kept very quiet and warm, and given tetanus antitoxin in every instance in which there is a break in the skin, as frequently deep punctured wounds are disguised by contusions and abrasions.

#### CASE REPORTS

Mrs. A. B. white, aged 48, lost control of her car and had a head-on collision. She was brought to the hospital by ambulance and when first seen she was in coma. Her skin was clammy and showed pitting edema over the entire body. Pulse rate was 160, heart fibrillating, blood pressure 98/40, and her right pupil was dilated. She was bleeding from both nostrils and from the right ear; there were multiple contusions on her body. External heat was applied, glucose and digitalis were given intravenously. She regained consciousness five days later. Subsequent examinations showed lineal fractures of the right temporal and parietal bones and pubis and ischium. She left the hospital 52 days after her accident completely recovered except for her cardiac condition which was of years' standing.

C. B. S., white male, aged 66, was struck by an automobile while walking on the highway. He was picked up by a motorist and brought to the hospital. He walked into the hospital and to the emergency room. His only complaint was a broken arm. Examination showed a pulse of 80, blood pressure 120/80, respiration 18. There were no contusions or lacerations on his body except a small bruise over the right humerus which was fractured through the middle of the upper third. This fracture was reduced and fixed without anesthesia and the patient put to bed although he insisted on leaving immediately. Within one hour he was in a state of collapse and died six hours later. Postmortem examination showed rupture of the ileum transversely 3 cm. in length.

The thought that I should like to leave with you is that no one, regardless of how thorough or painstaking he may be in his examination, can offer a prognosis in an injury from an automobile accident in less than twelve hours and more frequently it is twenty-four to forty-eight hours before the seriousness of many injuries manifest themselves. Injuries that occur in the usual hazardous vocations can be gauged with more or less accuracy by various means whereas the number of factors that enter into an automobile collision are legion.

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*Redstone Building.*



## DISCUSSION

*Dr. J. Ralston Wells, Daytona Beach:*

This timely subject that Dr. Hardee has just spoken on concerns all of us, regardless of what our specialties may be. Automobile accident injuries today are more prevalent and demand more acute attention than at any time in the past. Our machines are becoming faster, roads better, and children no better than they used to be; our careless drivers are probably on the increase. The idea of a road accident being a trivial affair should be relegated to "old surgery." The most trivial injury today may turn out to be the most serious problem we have to face.

Doctor Hardee spoke of using tetanus antitoxin in all cases where there is a break in the skin. I might say that in many cases it is necessary also to use gas bacillus antitoxin because at times patients who were well on the road to recovery have been found, on the second, third, or even ninth day, to be infected with gas bacillus, with its consequent complications, some of which are extremely difficult to deal with. In that connection probably the x-ray is one of our best aids in the early treatment of gas bacillus. The x-ray should be used in all questionable traumas.

Again, it may seem ridiculous to say that you can walk on a broken leg, but it has not been so very long since I saw a man who walked with a broken leg, following an automobile accident. There were several in the same accident and he said to take care of the other people first; he was walking around but had a large contusion on his left tibia. X-ray showed a complete transverse fracture of the tibia in excellent position. Should he have stumbled he would have had a rather nasty displacement.

An x-ray is not only justified, but many times should be demanded, particularly now that we have so much insurance and people "going to sue somebody." An unsuspected fracture may come to light three or four months afterward and be blamed on that accident. If we have a film, we have evidence that there was or was not, a fracture due to that particular accident.

Shock, as Doctor Hardee mentioned, is very important and should be considered. Shock may not be immediate, but may come two or three hours afterward. Delayed shock is rather hard to treat, is more complicated and more serious than immediate shock. Often we do not take the precautions that we would, had we known of shock at the moment or within a short time after the accident. I think that all victims of accidents, as Doctor Hardee stated, should be hospitalized or at least be carefully watched for a period of twenty-four hours. Remember in the skull the middle meningeal artery may be injured; the patient may be partly unconscious and then partly lucid, afterwards going into a deepening coma. Twenty-four hours will give a pretty safe time to prognosticate the seriousness of the injuries you are looking for. Where there are several people in an accident you may often overlook something that is perfectly obvious when making a more detailed examination. If these patients are kept under observation for twelve to twenty-four hours you will sometimes save yourself a very embarrassing situation.

As to the use of opiates: I use opiates freely in all cases except those involving the head. Where an opiate is used give a rather small dose and repeat if necessary, rather than an initial large dose. Do not cloud yourself as to a possible diagnosis. Drugs are of little value in the treatment of postoperative shock or pain except those we use hypodermically. Blood transfusions and glucose or acacia intravenously are life-savers in many instances. The fluid intake or water balance is very important and is very often a life-saving measure.

I consider it a privilege to discuss this excellent paper of Doctor Hardee. It is very timely and contains an immense number of ramifications that could only be touched on this evening. This subject is going to enlarge as time goes on and we should give it its proper attention now and thus avoid many sad disasters.

*Dr. Van William Burns, Stuart:*

This paper by Doctor Hardee is extremely timely because we who are general practitioners, country practitioners at that, and not specialists are called upon to treat accident cases myriads of times.

There are two points in Doctor Hardee's paper that I want to discuss particularly. The first is prognosis. Individuals, relatives and others, are constantly calling upon the doctor to know what his prognosis is. The prognosis in accident cases is extremely difficult because a vast majority of the minor injuries we see in automobile wrecks become serious. I recall one case in particular in which the patient was seen following an accident and he complained only of a mild contusion about his right shoulder. This patient was completely examined and nothing else could be found except some contused muscles about the right shoulder. The patient insisted on going home. Twenty-four hours later he was examined again. Nothing was found wrong with him then. He was instructed to be quiet and to stay in bed, which advice he did not heed. Six hours later this individual had a convulsion, became unconscious and was dead thirty-six hours later. Autopsy revealed a small hemorrhage. The emotional stress and strain had evidently caused the hemorrhage to increase.

The second point which he brought out was the use of prophylactic sera. It cannot be stressed too much. I think tetanus antitoxin should be given in all cases where there is any break in the skin whatsoever. It should be repeated within one week where the contused area is extensive. Gas vaccine should always be given when there is a deep wound or compound fracture.

## PERINEPHRITIC ABSCESS, ITS DIAGNOSIS AND TREATMENT

J. J. GUERRA, M.D.

Tampa

Clinically, it is impossible to distinguish between a perinephritis and a paranephritis but, theoretically, they both exist. The former may lead to the formation of a true perinephritic abscess and is defined as suppuration within the fascial capsule of the kidney; the latter may cause a false perinephritic abscess and may be defined as a suppuration occupying the retroperitoneal fat but originating outside the perinephric fascia and better termed a sub-diaphragmatic or paranephritic abscess.

The most common location of a perinephritic abscess is either the superior or the inferior pole or along the posterior border of the kidney. An abscess on the anterior surface of the kidney is very uncommon. The perinephritic fatty capsule is invaded in various ways:

1. Through the blood stream, the focus of infection being elsewhere in the body and usually a furuncle, carbuncle, or some other similar focus in the superficial tissues.

2. By extension of infection from a cortical abscess of the kidney to the perinephritic fat.

Read at Tampa Municipal Hospital, Tampa, on Hospital Day, May 12, 1938.



PLATE 1. Showing deviation of the kidney and the ureter anteriorly from normal position.

3. By extension of the infection by way of the lymphatics and usually from a cortical abscess because of the free communication between the renal and the perirenal lymphatics.

4. By extension of the infection from a retrocecal appendix.

5. By extension of the infection along the periureteral sheath or posterior peritoneum from the prostate, seminal vesicles, parametria, or bladder.

The causative organisms most commonly found are the staphylococci; however in perinephritic abscess, secondary to pyelonephritis, the organism most commonly found is the *B. coli* group.

The diagnosis of perinephritic abscess may be confused with traumatic rupture of the kidney, pyonephrosis, nephrolithiasis, renal or perirenal tumors, lumbar arthritis, lumbar hernia, retrocecal appendicitis, subdiaphragmatic abscess, gallbladder disease, tuberculosis of the spine or hip, osteomyelitis of the ribs,

or a ruptured viscus. Consequently, we must always bear these conditions in mind.

#### SYMPTOMS: SUBJECTIVE

1. Tenderness and rigidity—over corresponding iliocostal space.
2. Persistent high temperature.
3. Leukocytosis.
4. History of carbuncle, skin infection, etc.
5. History of trauma over kidney.
6. Thigh and leg of involved side usually found flexed.
7. A late symptom is that of tumefaction.



PLATE 2. Normal position of the average kidney and ureter in relation to the vertebral column.

#### OBJECTIVE: PLAIN X-RAY

1. Obscurity of psoas muscle shadow on affected side.
2. Irregularity of the renal outline.
3. Diaphragm is often elevated and fixed.
4. No renal mobility.
5. Deviation of the spine to the opposite side of the abscess.

#### EXCRETORY OR RETROGRADE UROGRAPHY

1. Filling defects or deformities of the renal pelvis and its calices due to pressure of the abscess.

2. Ureter deviated.

3. Kidney rotated and displaced mesially, laterally, upwards, or downwards.

4. A recent procedure developed as an aid to the diagnosis of perinephritic abscess is that of lateral pyelograms as brought out by John G. Menville in the *Journal of the American Medical Association*, July 16, 1938. The technic consists of having the patient lie on the affected side, perpendicular to the x-ray film, while the pyelogram is being made. This will show a displacement of the kidney and the ureter in a smooth, regular, elongated, arclike manner by the retroperitoneal accumulation of purulent material.

In early cases of perinephritic abscesses where only a few cubic centimeters of purulent material have accumulated, the displacement of kidney and ureter may be so slight as to be scarcely noticeable. However, if there is suf-

ficient infection to produce edema of the surrounding tissue, the kidney and possibly the ureter may be displaced, but not in an arclike way. The lateral pyelogram produces a typical deformity in advanced cases of perinephritic abscesses. In early cases, the displacement is slight. Any displacement of the kidney and the ureter anteriorly is suggestive of retroperitoneal pathology.

Menville in his paper makes no mention of the normal position of the kidney and the ureter in relation to the vertebral column in lateral x-rays. We have checked this in twenty-five different cases, and the shadow of the kidney, the pelvis, and the ureter in every case has been found to be well within the shadow of the column. This would seem to prove conclusively that any displacement anteriorly of the ureter and the kidney would indicate a pathological condition existing behind the kidney or the ureter or both.

#### CASE REPORT

Mrs. C. R., aged fifty-two years was admitted to hospital on January 10, 1939, complaining of pain in the right lower and upper quadrants and having a high temperature. The patient stated that on January 4 she had a sudden severe pain in the right lower abdomen which continued to grow worse; no nausea or vomiting, but slight diarrhea. From January 4 to January 10, she stayed in bed, using hot water bottles and mustard plasters on affected side. She stated that she had an elevation of temperature all this time, but no chills.

*Past History:* Pneumonia, at the age of 16 years typhoid at the age of 27 years; at no time did patient have any skin infection, carbuncle, or furuncle.

*Gastro-Intestinal:* Good appetite; no history of pain in stomach, gas, or indigestion; complained of slight constipation.

*Cardio-Respiratory:* No cough; dyspnea; no palpitation.

*Menstrual History:* Onset at age of 14 years; regular, normal duration. Nine full-term children; one abortion at six months. Last period four years previously.

*Genito-Urinary:* Slight nocturia past few years; gave indefinite history of recently having had burning and pain on urination; no hematuria; had never had pain in kidneys.

*Physical Examination:* A well-developed female, well nourished, complaining of pain in lower abdomen and malaise. Examination of the head and neck and chest did not yield observations of importance.

*Heart:* The blood pressure was 105/80. The heart sounds, distinct and normal; there was good rhythm, no murmurs; the pulse was regular with good volume.

*Abdomen:* There were definite tenderness and spasticity over the right lower and upper quadrants laterally and posteriorly. A definite tumor mass was felt below the costal margin anteriorly which did not appear to be movable. There were no pains, tenderness, or spasticity over the left abdomen.



PLATE 3. Return to normal of the kidney and the ureter shown in Plate No. 1 after operation for perinephritic abscess.



*Extremities:* An examination revealed nothing of importance except that the patient felt better with the right leg flexed.

*Laboratory Findings: Catheterized specimen:* Clear; alkaline; specific gravity 1012; albumin 2 plus; sugar, acetone, and diacetic negative; pus cells rare; blood cells few; casts negative.

*Blood:* Hemoglobin, 70 per cent; red blood count, 3,700,000; leukocytes, 15,000; polymorphonuclears, 90; lymphocytes, 10; nuclear index, 2.

*X-Ray Findings: Lateral Pyclography:* Both the plain and the injected plates revealed the kidney and the ureter were displaced anteriorly.

*Plain Film:* Anteroposterior view showed excess gas and obscurity of the outline of the kidney and the psoas muscle.

*Pyclogram:* A definite filling defect of the pelvis and the calices was revealed; the kidney was rotated and elevated. Pyclogram taken at inspiration and expiration showed no mobility of the kidney.

*Chest and Diaphragm:* Chest found negative. The diaphragm was elevated and fixed as revealed by fluoroscopic examination.

#### TREATMENT

It is agreed that prompt drainage through a lumbar incision be established as soon as diagnosis is made. Decapsulation with drainage of the abscess in diffuse coccal infection is recommended by Beer as the best form of treatment.

In cases where the kidney shows considerable destruction and suppuration continues, a secondary nephrectomy is advisable.

In the case under discussion, a right lumbar incision was made, and a considerable amount of pus, definitely colon bacillus, was found under pressure. The abscess cavity extended from the diaphragm down to the pelvis posteriorly to the kidney and the ureter. Three cigarette drains and two irrigating tubes were left in place. The wound was sutured in layers and irrigated twice daily. The patient had an uneventful recovery.

*X-Ray Findings: Lateral Pyclography—Postoperative:* Plates show that the kidney and the ureter have returned to normal position, and are well within the shadow of the vertebral column.

#### CONCLUSION

An early diagnosis and prompt drainage, or drainage and nephrectomy, as may be indicated, are essential in perinephritic abscess. The lateral pyclogram as brought out by Menville and which we have shown at this time is an aid to early diagnosis. However, no mention has heretofore been made of the normal position of the kidney and the ureter. We have shown in no less than twenty-five cases the relation of the normal position to the vertebral column; the kidney and the ureter lie normally well within the shadow of the column.

*First National Bank Building.*

## CAN THE MOSQUITO TRANSMIT SYPHILIS?

WILLIAM H. KUPPER, M. D.  
Miami Beach

The epidemiology of syphilis has been so conclusively shown to be by venereal means or by direct contact, that the possibility of any other means of transmission has been dismissed. The following paper will attempt to show why transmission of the *Spirochaeta pallida* by means of an insect vector, the mosquito, is an interesting possibility.

This idea presented itself to the author in 1937, during the course of a study of the Wassermann and Kahn reactions in malaria, conducted at the Florida State Hospital in conjunction with the International Health Division of the Rockefeller Foundation, the results of which were recently published in the *Journal of the American Medical Association*.<sup>1</sup>

Twenty-five non-syphilitic psychotic patients were inoculated with malaria by means of infected *Anopheles quadrimaculatus* mosquitoes. All of the patients developed clinical malaria, and all were found to have positive Wassermann and Kahn reactions by tests conducted at three different serological laboratories, viz., the hospital laboratory, the laboratory of the Florida State Board of Health, Tallahassee, and the laboratory of the Georgia State Board of Health, Atlanta. These findings were unusual enough although they did confirm the work of Hopf<sup>2</sup> who had used a similar technique, but further surprises were not lacking. *Two non-syphilitic patients who were negative clinically and microscopically for malaria, were found to have developed positive serological reactions.*

One of these individuals was a colored woman, aged 30, diagnosed as dementia praecox, whose blood and spinal fluid were negative previous to inoculation. On the 30th day following inoculation, the Kahn reaction became positive, and on the 32nd, and 39th days following inoculation, the Wassermann reaction was positive. The other individual was a white male, aged 20, diagnosed dementia praecox, whose blood and spinal fluid were likewise negative previous to the application of mosquitoes, but who was found to have a positive Wassermann on the 11th, 21st, 35th, and 40th days following mosquito inoculation. No quin-

ine was administered to either one of these patients, and all positive reactions were absent a few months later.

Omitting the possibility of technical error (more than one laboratory was involved), or the possibility of latent malaria causing the positive reactions (subinoculation of blood from one of these patients to a susceptible individual did not produce malaria), the chance that the *Spirochaeta pallida*, or some form of it was transmitted by the mosquitoes all of which had originally fed on neurosyphilitics, could not entirely be ruled out. One patient gave a history of hookworm infection; the other of tubo-ovarian disease, but it is hard to believe that these diseases could influence the serological reactions at the time the experiment was conducted.

An investigation of the literature revealed one report<sup>3</sup> of syphilitic infection which was suspected of having been acquired by means of a mosquito bite. In an article entitled "Syphilis and Mosquitoes," Belgodere (1920) tells of a case of syphilis discovered in a French artillery officer who had been in the front line trenches for a long period. Three months previously, this man had been bitten on the dorsum of his right hand by a mosquito. The bite had been treated with tincture of iodine. It was purple, slightly infiltrated and oval and was the only known lesion in this case. Because of the good character of this patient and his known period of residence away from promiscuous contacts, Belgodere speculates on the possibility of a mosquito bite being the source of the infection.

An inquiry shows that there is considerable theoretical evidence pointing to such transmission. It was discovered that McDonagh,<sup>4</sup> a prominent English syphilologist had long held that the *Spirochaeta pallida*, or the *Leucocytozoon syphilidis*, as he called it, has a life-cycle analogous to that of the malarial parasite. McDonagh published photomicrographs of stages of a life-cycle, and described the development of the *Spirochaeta pallida* with the terminology in use in malaria:

The life-cycle (of the *Spirochaeta pallida*), commences with a spore, or as it is generally called, a sporozoite. The sporozoite when examined *in vivo* remains for some time unstained. Later it stains very deeply but its motility is not thereby impaired. It is seen in two forms, (A) circular, (B), renal-shaped. Its size is about 1.5u in diameter, and it is actively motile. Besides being found in the scrapings from syphilitic

lesions, it may be found in the blood withdrawn from the healthy skin surrounding a chancre, and also in the blood stream, during the stages of general infection. The sporozoite then becomes intracellular. On two occasions I have seen it in a small mononuclear leucocyte. It remained actively motile while within and it ultimately left the cell. It chooses a connective tissue cell, or an endothelial cell as its host, and when inside, it undergoes important changes.

McDonagh then goes on to describe the *Spirochaeta pallida* as having gametocytes, and a process of fertilization similar to that occurring in malaria.

If McDonagh's theory is correct, an insect vector would seem logical. McDonagh himself considered such a possibility but dismissed it on the grounds that the epidemiology of syphilis was already so well known that it was not necessary to search for other methods of transmission.

It is interesting to note that every one of the organisms which is definitely known to produce serological reactions,<sup>5</sup> either has an insect vector, or has been suspected of having one, viz.: *Treponema recurrentis* (lice, ticks); *Treponema pertenue* (the gnat, *Hippelates pallipes*)<sup>6</sup>; *Plasmodium vivax* (*Anopheline* mosquitoes)<sup>1</sup>; *B. leprae* (flies, bedbugs, mosquitoes?)<sup>7</sup>; trypanosomes (tsetse fly).

Examples of life-cycles of spirochetes in insects are represented in the case of the relapsing fever spirochetes (*Treponema recurrentis*) and chicken spirochetes (*Treponema gallinarum*),<sup>8</sup> both of which undergo complicated life-cycles characterized by granular and infravisible stage, in the bodies of insects (lice and ticks). A few examples of spirochetes found in insects are quoted from Wenyon:<sup>9</sup>

<i>Treponema glossinae</i>	— <i>G. palpalis</i>
" sp.	— <i>Aedes argenteus</i>
" <i>phlebotomi</i>	— <i>Phlebotomus perniciosus</i>
" <i>culicis</i>	—Larvae of <i>Culex</i> sp.
" sp.	—Larvae of <i>Anopheles maculipennis</i>

Stokes<sup>10</sup> has said "... perhaps the spirochetal form we see is only a concomitant, a saprophytic camp-follower, of a missing something else. Perhaps the spirochete is merely an end product of an evolutionary cycle, and in itself cannot reproduce the disease." Ingraham<sup>11</sup> has discussed the subject of the life-cycle of the *Spirochaeta pallida* thoroughly, and quotes many points in favor of it.

Turner,<sup>12</sup> who has shown the transmission of the yaws spirochete by the gnat to be possible, in a personal communication to the author states: "The weight of evidence at the

present time is against the existence of a complicated life-cycle of the *Treponema pallidum*, but I am not sure that this altogether rules out the possibility that mosquitoes may transmit the disease."

The author's idea is that mosquito transmission of the *Spirochaeta pallida* may be a minor mode of the spread of the disease, or may not occur outside of the laboratory at all as is the case in malaria which is uncommonly transmitted in nature by the mosquito *Anopheles punctipennis*, but which can be transmitted by this species of mosquito, experimentally in the laboratory.

It would seem a matter of great interest to investigate this problem, using cases of syphilis in *early stages* for the mosquito feedings, and applying these mosquitoes to experimental animals. Certainly this enigma calls for solution.

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## BIDWELL T-FRAME, LEG SETTING APPARATUS

A. M. BIDWELL, M. D.  
Tampa

The idea for this frame came to me while Chief Consultant, Orthopedic Surgeon, Base Hospital 69 AEF France, 1918-19. It was found that not only were extra men required to hold the legs of a patient but also something to maintain the injured leg in position after x-ray and during application of cast was necessary. To accomplish this the army mosquito bar was used. This bar, made of iron in the form of a T, was bent to give 3 legs and a suspension bar. This proved of great help in obtaining good results. From this gradually developed the present frame.

Fresh fractures should be reduced immediately or at least within a few hours after incurrence. Fresh fractures should not be immobilized in a plaster cast but on a suitable splint for 24 to 48 hours, until maximum swelling has occurred and is subsiding. For this purpose a right-angle wood splint, properly padded, will suffice. Any good carpenter can make such a splint at little expense.

For the splint the material suggested is white wood, finished,  $\frac{3}{8}$  inch thick and 4 inches wide. For a man of average height the foot piece is 12 inches long, the leg piece 17 inches, joined with nails at right angle. On either side where leg and foot pieces are joined is nailed a triangular piece 4 inches up on foot and leg piece from angle. This splint is then properly padded, using uninjured leg as a model.

The leg is pulled down, splint applied and fastened with 2-inch adhesive bands to distal fragment, fracture adjusted, and then upper fragment fastened to splint in like manner. Gauze dressing and bandage are then applied and kept wet with water every two hours over site of fracture to relieve soreness and reduce swelling.

In 24 to 48 hours 3-inch muslin slings are passed under the leg; the leg is lifted in proper relation to the T-frame on right angle wood splint; slings are made fast to and suspended on T-frame. Then the right angle wood splint is dropped down from under leg. In this way the fracture is not disturbed at all. If the

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fracture was set well to begin with, it may need little if any adjustment.

The Bidwell T-Frame weighs 10 pounds knocked down, is packed in a wooden box weighing 4 pounds, which is  $54 \times 5\frac{1}{4} \times 3\frac{3}{4}$  inches, making the total weight 14 pounds. The frame consists of 10 pieces, 5 main and 5 accessory.

Diagram 1 shows the leg suspended on the 5 main pieces. Diagram 2 shows the leg suspended on the 5 main pieces, the 5 accessory pieces having been added with longitudinal countertraction and lateral traction. In those cases requiring suspension only, the 5 main pieces are used, and assemblage is as follows:

Assemblage of the 5 main pieces is shown in Diagram 1. Each of the pieces of the frame



DIAGRAM 1

in the diagram is numbered. It will be noted that the top of T-1 has 3 holes, the middle round for perineal bar, and one oblong either side for tail of T-4. When the left leg is suspended, the left oblong opening is used; when the right leg is suspended the right oblong opening is used. There are inserted in the top of T-1 at its ends upright 2 and 3 at its middle, right or left, tail of T-4 at end of No. 4 upright No. 5, the slot in No. 5 facing away from the frame.

These 5 main pieces are fitted together by mortise and tenon. The tenon is left long and has a small square hole near its end, through which is slipped a small wedge to hold it firm. There is one of these small wedges, four in all, placed at the upper end of uprights. Nos. 2, 3, 5 and at end of No. 4 after it passes through No. 1.

In those cases requiring lateral traction in addition to suspension on 5 main pieces, the 3 accessory pieces 8, 9 and 10 are also used, and assemblage is as follows:

Assemblage of accessory pieces 8, 9 and 10 on 5 main pieces is shown in Diagram 2. Crossbar No. 8 is placed in its position on No. 5, the slot in No. 8 facing toward frame.



DIAGRAM 2

The short part of No. 8 is placed on the same side on which the leg is suspended. Into No. 8 are inserted Nos. 9 and 10 at one end, and into uprights Nos. 2 and 3, respectively, at the other end which form the two side bars for lateral traction.

In those cases requiring longitudinal countertraction in addition to suspension and lateral traction the 2 accessory pieces, Nos. 6 and 7, are also used, and assemblage is as follows:

Assemblage of accessory pieces 6 and 7 on five main pieces in addition to accessory pieces 8, 9 and 10 already assembled is shown in Diagram 2. The round perineal bar No. 6 is inserted into No. 1; bottom bar No. 7 is slipped into its slot at lower end of Nos. 6 and 5. It will be noted that the bottom bar No. 7 at one end has a longitudinally cut tongue and at the other end an obliquely cut tongue. The longitudinally cut tongue fits into the slot at the lower end of the round perineal bar No. 6. The obliquely cut tongue fits into the slot of the lower end of the upright No. 5. The obliquely cut tongue points away from the side on which the tail of T-4 is placed. When used on the right the reverse side is up from that used on the left.

For the suspension slings, muslin bandage is used, in adults 3 inches wide, in children under 12, 2 inches wide. The sling is passed around the leg and held close to it by making a half tie on the anterior surface. The two long ends by which the leg is suspended are parallel and close together, thus permitting plaster

bandage to be rolled with only a small opening at each sling.

For longitudinal countertraction there is placed at each ankle with muslin bandage, a clove-hitch. The muslin band is left long and on the good leg fastened to the lower part of upright No. 5 (See Diagram 2-E). The clove-hitch on the ankle of the injured leg is left long and fastened to upright No. 5 just above cross bar No. 8 (See Diagram 2-D).

In Diagram 1 are shown three slings, A, B and C, A supporting knee, B supporting heel, and C at site of fracture preventing posterior bow. In Diagram 2 is shown lateral traction bands G and F at site of fracture correcting lateral bow.

The fractured leg is suspended on T-frame by muslin bands as above indicated. The foot ordinarily is held at right angle and slightly inverted. To accomplish this purpose, usually the muslin sling (See Diagrams 1 and 2, Item B) is crossed over the ball of the foot before being brought up to bar No. 4. In some cases a 2-inch band of adhesive (See Diagrams 1 and 2, Item H) is also necessary. After alignment has been obtained the fracture is x-rayed; if not satisfactory, adjustment is made and re-x-rayed. After x-ray examination shows position satisfactory while the leg is still held suspended on T-frame, a circular plaster cast is applied and allowed to set. The bands are then cut and the leg let down. After this it may again be x-rayed if desired. By this method of holding the leg still in same position after last x-ray and during application of cast one is assured of maintaining position.

Below are some of the fracture cases in which this frame is applicable and manner of applying casts:

1. Metatarsals: cast, from mid-leg to tip of toes.

2. Pott's fracture: cast, from below knee to tip of toes.

3-4-5. Tibia, fibula or both, lower  $\frac{2}{3}$ : cast, from below knee to tip of toes.

6-7-8. Tibia, fibula or both, upper  $\frac{1}{3}$ : cast, from trochanters to tip of toes.

9. Patella: cast, from trochanters to malleoli.

In patients of ordinary height, a regular examining table is all that is necessary. In very

tall patients for fractures 1 to 5 inclusive, the patient may rest back against the wall, or, if necessary to lie down, a small square dressing table may be placed at the foot end of the examining table which will give ample table length. In fractures 6 to 9 inclusive, the torso and head are raised from the table about 4 inches by books or a suitable small wooden platform to give clearance to the upper part of the thigh in rolling plaster bandage.

The frame adapts itself to use: on examining table in physician's office; on x-ray table; on bed, in patient's residence, and in the hospital.

Among the advantages of the frame may be listed:

1. Eliminates extra assistants.
2. Facilitates reduction of fracture.
3. Holds suspended in position previous to cast for x-ray.
4. Avoids change in position resulting in angulation, especially posterior sag during application of cast.
5. Wood, light, durable, easily portable, easily assembled and knocked down.
6. Wood does not throw x-ray shadow.

The usual method of an assistant holding the foot in his hands while the surgeon applies the cast is prone to result in some angulation at the site of fracture. It is next to impossible, if not impossible, in case of complete fracture, to hold the leg in a proper position while the cast is applied without suspension, which is accomplished by Bidwell T-Frame.

The two principal angulations, (a) posterior, causing center of weight to be placed too far back on heel, (b) inward, causing center of weight to be placed at inner side of foot with resulting talipes valgus, are both easily avoided.

The T-frame eliminates the need for various recent types of metal traction apparatus using wire rods passed through bones, which requires the patient to remain in bed. The difficulty is not so much in reducing the fracture as in holding it in place until the plaster cast is applied. With Bidwell T-Frame in vast majority of cases this is accomplished, allowing the patient to be ambulatory with crutches.



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## SCIENTIFIC PROGRAM—TAMPA, 1940

An opportunity will be given to twenty members of the Association to read papers at the annual convention April 29, 30, and May 1, 1940, at Tampa. Dr. Walter C. Jones, Chairman of the Association's Committee on Scientific Work, mailed a letter to each member the early part of October, outlining the methods to use in making application for a place on this program.

To make the program interesting and worthwhile, well prepared papers from various fields of medicine should be presented. The Committee desires papers that have first been read before a county medical society and approved by its president or secretary. However, papers which have not been presented before any society may be submitted for consideration. The Committee is desirous of papers on the specialty subjects, particularly with their relation to the general practice of medicine. It feels that the fields of pediatrics, neurology, gastro-enterology, ophthalmology, otolaryngology, etc., should be covered. Members applying for a place on the program are requested to submit their papers in full, for consideration of the Committee. All applications must be received by the Committee not later than January 5, 1940.

At the six medical district meetings a total of twenty-four scientific papers will be presented. Any member desiring to read a paper at his medical district meeting in 1940 is requested to make application before January 5, 1940. The Association's Committee on Scientific Work will arrange the scientific program for the medical district meetings.

Every effort will be made to present the best programs possible at the annual convention and the medical district meetings. Mail your applications to the Chairman of the Scientific Work Committee, Box 1018, Jacksonville.

## STATE BOARD OF HEALTH DISTRICTS ABOLISHED

The State Board of Health has acted upon the recommendations propounded by the American Public Health Association, following a recent health survey in Florida. One of the foremost of these recommendations was the discontinuance of the five district offices of the State Board, located at Marianna, Jacksonville, Ocala, Bartow, and West Palm Beach. Emergency service will henceforth be given from the central office in Jacksonville.

There are many sound reasons for the recommendation. The American Public Health Association in its survey pointed out that "the district service has not only been of doubtful value but it has been detrimental to the establishment of full time health units, because in many areas the people did not realize the value of full time local health service and were therefore satisfied with mediocre district service, which is ineffective and extravagant." It is manifestly impossible for a district office to give effective health service over an area of twelve or more counties, including in the neighborhood of 300,000 people.

Florida at the present time has sixteen full time county health units and the discontinuance of district offices will undoubtedly do much to increase this number. A county health unit places the responsibility for health service squarely upon local governments. It is operated and partly financed by the county with the State Board of Health serving in an advisory and supervisory capacity. Certain monetary contributions are made by the Federal Government and the State of Florida which are

contingent upon the proper administration of the unit. Unless modern methods of public health procedure are followed and a personnel employed which is especially trained in public health, these funds may be withheld.

The Florida State Board of Health has taken a step forward by abolishing an antiquated system of public health service.

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### SELECT YOUR DELEGATES THOUGHTFULLY

The selection of capable doctors to represent county medical societies at the next meeting of the House of Delegates is of prime importance. The first meeting of the House of Delegates is scheduled for Monday, April 29, 1940, at Tampa. It is the legislative body of the State Medical Association and delegates should be selected, who are interested in the problems of the profession and are representative doctors in their county medical societies.

The Executive Committee, through the Association's secretary, has made an appeal to the president of each county medical society in the state to give this matter careful attention. It is an honor and a responsibility to be seated in the House of Delegates and all members should exercise their voting rights in selecting those most fitted for the office. The Association is growing and expanding rapidly, necessitating added responsibilities in the deliberations at the meetings of the House of Delegates. When the time comes for the election of the officers of your county medical society, you are urged to give particular attention to the selection of the delegates who will represent you in the legislative body of the State Association.

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### WARNINGS AGAINST SWINDLERS

Harvard Medical School, Boston, has received reports that a magazine salesman has been soliciting subscriptions alleging that he is a student at Harvard and is attempting to earn money for further medical study. The medical school reports that this man, who calls himself Chester Wainwright, is not known and has never been a student there.

Reports have recently come from Missouri of a man who has swindled ophthalmologists in various towns by ordering glasses and making a check for a larger amount than the price. The physician makes change and the man

never returns. The swindler has used the name of W. C. Curran and appears to be a farmer. The check is usually for \$30. The man is about 5 feet 10 inches tall, weighs about 155 pounds, has light sandy hair and blue eyes and is smooth shaven with a ruddy complexion. *J. A. M. A., Oct. 21, 1939.*

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### OUR ADVERTISERS

Our advertisers are our partners in the project of The Journal. Oh yes, we *could* get along without the help of our advertisers, but we are grateful to them for paying the costs of the mechanical production and distribution of our monthly periodical, and then, too, our members appreciate the information and educational value of the advertisements to themselves personally. For one thing, our acceptance of an advertisement amounts to an endorsement of the product or service of the advertiser, especially of his character and reliability. Also, the advertisements constitute an index of the sources from which products or services may be obtained.

One of the most pleasing and satisfactory evidences of the mutual appreciation of advertisers and users of their products is that afforded by the commercial exhibits at the annual meeting. There, sincere appreciation and good fellowship prevails between the representatives and the doctors, just as it does between the physician and his patient.

An advertisement in The Journal is like the doctor's sign over the door of his office. Only a small proportion of those who pass by the sign ring his door-bell; but if his sign is not in plain sight, he may as well close up. Only a few doctors read the advertising pages of our Journal from end to end, but some really do, and more actually complain when they cannot find the advertisement giving the address of the dispenser of a product which they must have in a hurry.

About one-half of our advertisements come to us from the Cooperative Medical Advertising Bureau of the American Medical Association, whose sole function is to place the announcements of the leading manufacturers of medical products which have a nation-wide distribution. A favorite device for testing the effect of the advertisements in the State Medical Journals is the use which physicians make of coupons offering samples or literature. One publisher of an expensive encyclopedia refused to renew his advertisement in the journal of one of the large medical societies because he had not received a single request for sample pages which he had offered. He said in a half joking way, "If I receive four coupons from an announcement in the forthcoming issue of your journal, I will immediately renew the advertisement." It happened that he received twelve requests, and he gladly kept his word.

Every doctor sees these coupons and other offers in our Journal, and many physicians are inclined to respond to them, but neglect to do so. If you are really interested in the offer, as many of you are, make use of it at once. This is especially important during the coming Fall months when decisions for renewing the advertisements are made, based on the tangible evidence that the advertisements are actually read and appreciated.

It is a gratifying fact that several large advertisers are seriously contemplating placing trial advertisements in the State Journals. Although you may not recognize your prospective customers, send for the coupons and literature that are offered in The Journal, and thereby demonstrate your interest in The Journal as well as the products which you will receive.

Finally, remember this fact: If it were not for the contributions of our advertisers, your annual dues would be increased.

*The Journal of the Medical Society of New Jersey,  
October, 1939*



## CITIZENSHIP MAY BE REQUIRED TO PRACTICE MEDICINE IN TEXAS

Citizenship may lawfully be required by the State of Texas of an applicant for a license to practice medicine, as a condition precedent to the issue of a license, in the opinion of the district court of Travis County, Texas, *The Journal of the American Medical Association* for Oct. 14 states in an editorial outlining the ruling.

Such a requirement was held not to deprive an alien of any right guaranteed him by the federal constitution. As far as available records show, this is the first time that a court has been called on to pass directly on this question. Under the provisions of the constitution a state cannot deny to an alien the right to follow a "common occupation under the same conditions that it imposes on citizens." The practice of medicine, the Texas court observed, is not "a common occupation" but is a profession impressed in many instances with semiofficial duties.

Physicians have duties in connection with many important matters relating to the public welfare; duties in connection with governmental birth, sickness and death records; with the execution of certificates of inability of witnesses, or even of the defendant, to attend trial; with matters relating to communicable diseases and quarantine; with the execution of certificates of freedom from disease, required by law in connection with the issuance of marriage licenses, and with the enforcement of state and federal narcotic laws and many other duties of similar nature. All these duties are imposed on physicians by the government in the furtherance of policies adopted by the state for the welfare of the people as a whole. A physician who is a citizen will be better able to cooperate with the state in carrying out its policies than a physician of foreign allegiance and training who is unfamiliar with the ideals and institutions of our country.

In epidemics, the court pointed out, the closest cooperation is required between the medical profession and various governmental agencies. The virtual end of epidemics of many diseases, such as cholera and smallpox, has resulted from the close partnership that has been maintained between the practicing physicians and administrative agencies of the state and federal governments. For the preservation of gains that have been made and in the furtherance of similar objectives, the court thought that the legislature had a perfect right to declare it to be of utmost importance that the practice of medicine be limited to citizens. Again, in time of war the services of physicians constitute a necessary and most important link in our fighting forces; the court thought that physicians who have not signified a belief in the fundamental ideals of this country would be in a position to exert a subversive influence tending to undermine and destroy those ideals and to thwart the attainment of the objectives for which we might be fighting. For these and other reasons the court felt that it was within the police power of the state to deny to aliens the right to practice medicine to the end that public health, safety and morals might be furthered and preserved.

The court, incidentally, expressed great difficulty in understanding why Texas had ever permitted examinations for medical licensure to be conducted in any language other than English, believing a thorough knowledge of our language to be of prime importance to a physician if he is fully to understand the information imparted by a patient and if he is adequately to give instructions to that patient.

In another editorial in the same issue *The Journal* points out that:

Numerous alien physicians, and particularly physicians from Germany and the nations it has taken over, have been coming into the United States during recent years for permanent residence. In some states difficult situations have been created. During the eight federal fiscal years immediately preceding June 30, 1938, 3,165 immigrant physicians arrived, of whom 1,221 came from Germany and Austria. During the following fiscal year, which ended June 30 last, immigrant physicians numbered 1,384, of whom 819 came from Germany, which during that year absorbed the area formerly known as Austria. During the fiscal year 1931, immigrant physicians numbered 329, while during the fiscal year 1939, just ended, they numbered 1,384.

How and where these 4,549 alien physicians are now located, what they are doing and what their prospects are of establishing themselves in the practice of their profession, if they have not already done so, is not known. Those who have not yet become United States citizens or even taken out first papers are confronted by statutes and regulations which, except in four states and the District of Columbia, will bar them from licenses to practice.

Statutes and regulations governing license to practice are summarized as follows:

Citizenship is required by statute in Arkansas, Delaware, Florida, Georgia, Idaho, Louisiana, Nebraska, New Hampshire, New Jersey, South Dakota, Texas and Wyoming, and by regulation of medical examining board in Alabama, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Montana, Nevada, North Carolina, Oklahoma, South Carolina, Tennessee, Washington, and West Virginia.

First papers are required by statute in Connecticut, Illinois, Massachusetts, New Mexico, New York, Pennsylvania, Rhode Island and Wisconsin, and by regulation of medical examining board in Colorado, Maine, Maryland, Mississippi, North Dakota, Ohio, Oregon, Utah and Virginia.

Neither citizenship nor first papers are required in Arizona, California, the District of Columbia, Indiana and Vermont.

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## MEDICAL DISTRICT MEETING—F West Palm Beach, October 12

The third annual meeting of the Southeast Medical District was held at West Palm Beach, Thursday afternoon at 2:30, October 12, with headquarters at the Palm Beach Yacht Club. There was a total registration of 117, of which number 81 were Association members (from this district, 75); 8 were visitors; and 28 were ladies. The names of the ladies who registered will be found on page 258 of this Journal.

The meeting was called to order at 2:45 p. m. by Dr. Lloyd J. Netto, senior councilor. In the absence of Dr. Gaylord Lewis, presi-



dent of the Palm Beach County Medical Society, Dr. G. W. Heath gave the address of welcome. General announcements relative to entertainment for the doctors, guests and ladies were made by Dr. F. K. Herpel, chairman of the local Committee on Arrangements.

Dr. Leigh F. Robinson, president of the State Association, the first speaker, outlined accomplishments so far this year, and commented on the activities of the headquarters office, various committees and groups. In the absence of Dr. Herman Watson, Chairman of the Council, his report was given by the junior councilor of the district, Dr. Kenneth Phillips. The following officials and committee chairmen were recognized and gave brief talks: Dr. J. Sam Turberville, president-elect; Dr. Gilbert S. Osincup, Chairman of the Executive Committee; Dr. Walter C. Jones, Chairman of the Committee on Scientific Work; Dr. Harrison A. Walker, Chairman of the Committee on Medical Economics; Dr. Warren Quillian, Chairman of the Committee on Child Health; Dr. M. Jay Flipse, Chairman of the Committee on Tuberculosis and Public Health; Dr. Homer L. Pearson and Dr. W. Henry Spiers, past presidents; and Dr. A. B. McCreary, State Health Officer. The official representative from the Medical Postgraduate Course Committee was unable to be present but Doctor Netto, the presiding officer, supplemented the comments of Doctor Robinson on the importance and value of the work of this committee and passed around questionnaires prepared by Doctor Cason. These questionnaires, filled out by those in attendance at the medical district meetings, are to be used by the Committee as a guide when making plans for next year's postgraduate course.

The question of a meeting place for 1940 was then taken up. Dr. M. Jay Flipse, president of the Dade County Medical Society, extended an invitation for Miami but later accepted a suggestion that a study be made of the possibility of holding the meeting with some smaller group which has, as yet, not had the privilege of entertaining a district meeting. If an invitation is not received from some smaller city, Doctor Flipse's invitation to Miami was to be accepted.

Doctor Netto announced that, after an intermission of ten minutes, the scientific session would convene.

*(Dr. Kenneth Phillips, councilor of District 12, has exchanged communications with Dr. W. R. Warren, secretary of the Monroe County Medical Society, relative to the advisability of holding the 1940 annual district meeting in Key West. Doctor Warren advised that the Monroe County Medical Society voted unanimously to extend an invitation. Naturally the doctors in Key West desired to be familiarized with what the undertaking involved and Stewart Thompson was, therefore, requested to make a personal visit, which he did on Wednesday, November 1. A week-end excursion has been suggested, with Saturday afternoon devoted to the meeting and Saturday evening and Sunday to the unique entertainment which the hosts will arrange. Doctors and their ladies from any section of Florida will be privileged to attend. Doctor Phillips contacted Dr. Lloyd J. Netto, senior councilor in the district, and together they officially designated Key West as the place for the 1940 district meeting.)*

At 4:35 p. m., Dr. Kenneth Phillips, junior councilor, called the scientific session to order. Four excellent papers were read and discussed. The interest in the scientific program was evidenced by the fact that 75 doctors sat through the entire session and gave close attention. Those appearing on the program were as follows: Dr. E. C. Chamberlain, Ft. Lauderdale, "Isolated Myocarditis"; Dr. Hillard W. Willis, Coral Gables, "Nephritis in Children" (illustrated); Dr. George D. Lilly, Miami, "The Surgical Treatment of Essential Hypertension" (illustrated); and Dr. Carlos P. Lamar, Miami, "Clinical Endocrinology of the Male, with Especial Reference to the Male Climacteric."

From 6:20 to 7:20 the entire group enjoyed cocktails and refreshments, served by the Palm Beach County Medical Society. The members of the Woman's Auxiliary and lady guests joined the doctors for this social hour which proved to be a very pleasant occasion. At 7:30 a buffet supper was served in the basement of the Palm Beach Yacht Club, with more than 100 of the doctors and guests attending. By unanimous vote, an expression of appreciation was extended to the doctors and their wives of the Palm Beach County Medical Society, hosts and hostesses at this annual district meeting.

## REGISTRATION—DISTRICT F

*Officers:* Lloyd J. Netto, West Palm Beach, Senior Councilor; Kenneth Phillips, Miami, Junior Councilor; Stewart Thompson, Jacksonville, Managing Director.

*Arcadia:* H. P. Bevis. *Century:* J. S. Turberville. *Coral Gables:* Warren W. Quillian, H. W. Willis. *Dania:* Paul G. Shell. *Ft. Lauderdale:* Russell B. Carson, E. C. Chamberlain, R. L. Elliston, E. M. Hendricks, J. W. McMurray, F. D. Pierce, Leigh F. Robinson, C. H. Sory, L. L. Stepp. *Jacksonville:* A. B. McCreary. *Lake Worth:* Grace E. Papot. *Miami:* R. N. Burch, L. W. Dowlen, M. Jay Flipse, Edward F. Fox, Bessie S. French, Francis W. Glenn, Walter C. Jones, Carlos P. Lamar, George D. Lilly, P. J. Manson, P. D. Melvin, James H. Mendel, John D. Milton, R. Sam Mosley, E. S. Nichol, R. K. Nuzum, William Pallister, Homer L. Pearson, J. Randolph Perdue, C. Larimore Perry, Wiley M. Sams, J. S. Stewart, J. I. Thorne, F. A. Vogt, Lynn W. Wheelchel, Frank M. Woods. *Miami Beach:* W. A. Christian, O. S. Dowlen, L. W. Elgin, David W. Exley, George N. Leonard, W. Duncan Owens, N. O. Pearce, Edwin P. Preston, Harrison A. Walker, A. W. Wallace. *Miami Springs:* Estella G. Norman. *Orlando:* L. C. Ingram, Gilbert S. Osincup, W. H. Spiers.

*Palm Beach:* B. B. Sory. *Pompano:* George S. McClellan. *West Palm Beach:* James L. Carlisle, Thomas E. Daly, George M. Dawson, C. J. Derrick, William H. Gardner, O. B. Hazen, G. W. Heath, F. K. Herpel, V. M. Johnson, J. C. Nowling, S. Richard Ombres, J. H. Pittman, L. M. Rozier, C. W. Shackelford, Michael Smith, J. R. Sory, Edgar W. Stephens, V. D. Stone, W. E. Van Landingham, William H. Weems, W. C. Williams, Jr.

*Visitors—Ft. Lauderdale:* Robert Blessing. *Miami:* P. H. Rezek. *Miami Beach:* F. H. Dieterich, R. T. Wagner. *West Palm Beach:* W. E. Bippus, E. B. Gray, T. Z. Stanley.

## MEDICAL DISTRICT MEETING—B

The third annual meeting of the North Central Medical District was held at Ocala, Thursday afternoon at 2:30, October 26, with headquarters at the Marion Hotel. There was a total registration of 70, of which number 47 were Association members (from this district, 36); 6 were visitors; and 17 were ladies.

The general session was called to order by Dr. James L. Strange, senior councilor. Dr. Carl S. Lytle, president of the Marion County Medical Society, gave the address of welcome. Dr. Leigh F. Robinson, president of the Association, was then called on and gave a very interesting outline of his and the standing committees' activities so far this year. Dr. Shaler Richardson, secretary-treasurer and editor of the Journal, reviewed the work going through the Association's office, commenting on the coverage of the Journal and Medical Directory and various activities of the Association. He emphasized the fact that it is the Doctors' Journal and urged that constructive criticisms and comments be submitted in order that the Journal and office may

function according to the wishes of the members.

Dr. Herman Watson, chairman of the Council, presented a very interesting report of the Council's activities. Dr. George C. Tillman outlined the work of the Association's Committee on Medical Postgraduate Course. Dr. Gilbert S. Osincup, chairman of the Executive Committee, gave a brief outline of the changes in the schedule for the 1940 convention and new procedure in the House of Delegates, having to do with reference committees, etc. Dr. W. Henry Spiers and Dr. H. C. Dozier, past presidents, were recognized and Dr. A. B. McCreary, State Health Officer, was extended the courtesy of the floor for a brief address.

Dr. R. B. Harkness of Lake City extended an invitation on behalf of the Columbia County Medical Society, to hold the next annual district meeting at Lake City. On motion, the invitation was unanimously accepted.

After a short intermission, Dr. William S. Nichols, junior councilor, called the scientific session to order for the following program: "Hygiene of the Eyes" (illustrated) by Dr. Ralph E. Russell, Ocala; "Cervical Ribs" by Dr. Laurie J. Arnold, Lake City; "A Young Doctor Looks at Socialized Medicine" by Dr. Richard C. Cumming, Ocala; and "Syphilis—General Consideration" by Dr. W. E. Murphree, Raiford.

At 6:30 the doctors, guests and ladies enjoyed the cocktail hour in the veranda room of the hotel. After this social hour the group retired to the dining room where a most delightful dinner was served.

## REGISTRATION—DISTRICT B

*Officers:* J. L. Strange, McIntosh, Senior Councilor; W. S. Nichols, Lake City, Junior Councilor; Stewart G. Thompson, Jacksonville, Managing Director.

*Brooksville:* G. R. Creekmore, S. C. Harvard. *Cross City:* J. M. Anderson. *Daytona Beach:* George M. Green, L. von Meysenbug. *Dunnellon:* Carl S. Lytle, B. S. Stutts. *Ft. Lauderdale:* Leigh F. Robinson. *Gainesville:* Edwin H. Andrews, John E. Maines, Jr., Thomas A. Snow, George C. Tillman. *Hawthorn:* G. M. Floyd. *Inverness:* C. L. Carter. *Jacksonville:* L. W. Holloway, A. B. McCreary, S. R. Norris, Shaler Richardson. *Lake Butler:* John E. Maines. *Lake City:* L. J. Arnold, Jr., T. H. Bates, R. B. Harkness, H. S. Howell, J. F. Pitman. *Lakeland:* Herman Watson. *Minocopy:* I. A. Dailey.

*Ocala:* J. L. Chalker, R. C. Cumming, H. C. Dozier, H. L. Harrell, E. G. Lindner, C. W. Mimms, J. N. Moore, E. G. Peek, R. E. Russell, E. Laurence Scott, T. H. Wallis, H. F. Watt. *Orlando:* A. C. Kirk, Gilbert S. Osincup, W. Henry Spiers. *Raiford:* W. E. Murphree. *White Springs:* D. N. Cone. *Williston:* J. M. Willis. *Zephyrhills:* D. B. Manley.

Visitors—*Dade City*: E. H. Brown. *Daytona Beach*: W. L. Jennings. *Jacksonville*: Mr. Wayne C. Hunt. *Lake City*: Harry R. Deane, Paul Morrison.

Ladies—*Brooksville*: Mrs. G. R. Creekmore, Mrs. S. C. Harvard. *Dunnellon*: Mrs. Carl Lytle. *Gainesville*: Mrs. Thomas A. Snow. *Lake City*: Mrs. L. J. Arnold, Jr., Mrs. W. S. Nichols. *McIntosh*: Mrs. J. L. Strange. *Ocala*: Mrs. Richard Cumming, Mrs. H. L. Harrell, Mrs. E. G. Lindner, Mrs. J. N. Moore, Mrs. Ralph Russell, Mrs. Laurence Scott. *Orlando*: Mrs. L. C. Ingram, Mrs. J. A. Pines. *Raiford*: Mrs. W. E. Murphy. *Zephyrhills*: Mrs. David B. Manley.

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## BIRTHS, MARRIAGES AND DEATHS

### BIRTHS

Dr. and Mrs. J. R. Sory of West Palm Beach announce the birth of a daughter, Martha Curry, on September 30.

### MARRIAGES

Dr. James A. Bradley and Mrs. Evelyn Neuling of St. Petersburg were married October 1.

Dr. Peter A. Drohomer of Daytona Beach and Miss Harriett Perry Coley of Palatka were married October 24.

### DEATHS

Dr. Joseph Lee Kirby-Smith of Jacksonville died at his home on November 5, following a brief illness.

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## STATE NEWS ITEMS

The Southeastern Branch Society of the American Urological Association will meet December 8 and 9, 1939, at the Buena Vista Hotel, Biloxi, Miss. A number of speakers of national prominence will appear on the program. Members of the Florida Medical Association are cordially invited to attend.

For programs and further information, address Dr. Louis M. Orr, 311 Exchange Building, Orlando, Fla.

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County medical societies wishing to entertain the 1941 annual convention of the State Association are required to have their invitations filed with the Executive Committee prior to or at the Pre-Convention Meeting which is to be held in Jacksonville, Sunday, January 21, 1940. See By-Laws, Chapter VII, Section 2.

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Dr. D. Ward White of Miami Beach spent three weeks this fall, vacationing and attending clinics in New York.

The following Florida doctors attended the annual meeting of the American Roentgen Ray Society in Chicago in September: J. M. Dell, Jr., Gainesville; W. McL. Shaw, Jacksonville; Alfred G. Levin and Gerard Raap, Miami; J. C. Dickinson and H. O. Brown, Tampa.

\* \* \*

Dr. Frank L. Quillman has resigned his position as county physician in Orange County, which he has held for the past three years, and opened an office in St. Cloud on November 1 for private practice.

\* \* \*

Dr. J. C. Robertson recently opened offices at Vero Beach. He was for eight years a staff member of the Florida State Hospital.

\* \* \*

Dr. Lauren Sonpayrac of Jacksonville spent three weeks in November for study at the New York Skin and Cancer Clinic.

\* \* \*

Dr. C. Larimore Perry of Miami attended a reunion of residents and ex-residents of Mayo Clinic at Rochester, Minnesota, recently.

\* \* \*

Dr. George E. Beckman of Jacksonville was certified by the American Board of Anesthesiology at Philadelphia in October.

\* \* \*

The American Board of Ophthalmology announces that a written examination is scheduled for March 2, 1940, in various cities throughout the country. This will be the only written examination in 1940. For application blanks and further information, address Dr. John Green, 6830 Waterman Ave., St. Louis, Mo.

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Dr. L. W. Glatzau of Daytona Beach finished a two-months' postgraduate course at Cook County Hospital in Chicago recently, majoring in otolaryngology. He returned home the latter part of October.

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The Physicians' Exchange of Miami is considering the installation of a short wave radio communication system which will make it possible for physicians to receive messages by radio within their automobiles.



Dr. Leroy Oetjen of Leesburg was recently elected president of the local Kiwanis Club. Dr. Clyde F. Bowie is one of the seven directors of the club.

\* \* \*

Dr. Earl C. MacCordy, president of the Pinellas County Medical Society, was principal speaker at a meeting of the Jaycees held the latter part of September. His subject was "Resuscitation."

\* \* \*

Dr. S. C. Harvard of Brooksville recently addressed the local Kiwanis Club on the subject of county health units.

\* \* \*

Dr. R. L. Hughes of Bartow spent the month of August on the Pacific Coast and in Mexico. Mrs. Hughes accompanied him.

\* \* \*

Dr. Jack Halton of Sarasota spent the late summer in Chicago and Cincinnati where he took postgraduate work in proctology.

\* \* \*

Dr. Bessie S. French of Miami left the latter part of October to take postgraduate work in anesthesia and cardiology at the Cook County Graduate School of Medicine in Chicago.

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Dr. Kenneth Phillips of Miami announces that the Miami Physical Therapy Center is now located at 1150 S. W. Coral Way and that fever therapy and physical therapy treatments are accepted only upon physicians' reference.

\* \* \*

Dr. E. C. Aurin has returned to Ft. Ogden after spending three months in Michigan, recuperating from a recent illness. Mrs. Ogden accompanied him.

\* \* \*

Dr. E. B. Woods of Tampa spent the first half of September doing special research work and attending clinics at Johns Hopkins University in the Department of Obstetrics and Gynecology.

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The following Florida doctors attended the meeting of the Southern Psychiatric Association, held in Louisville in October: W. C. McConnell, St. Petersburg; W. G. Miles, W. D. Rogers and Ralph E. Stevens, Chattahoochee.

Dr. P. D. Melvin of Miami spent his vacation in Philadelphia, visiting urological clinics.

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Dr. Sanford C. Colley of Mount Dora was recently appointed a lieutenant colonel on the staff of the Governor of Florida.

\* \* \*

Dr. R. Bradner Mertz of Tampa spent three weeks in October at the Mayo Clinic and attended the International Postgraduate Assembly in Chicago.

\* \* \*

Dr. F. S. Whitman of West Palm Beach has returned from New York City where he took a six-weeks' course in cardiology and cardiography.

\* \* \*

The annual scientific meeting of the Georgia Pediatric Society will be held in Atlanta on Dec. 16, 1939. A luncheon at 12:45 will precede the afternoon session, which will convene at 2 o'clock. The evening meeting will be held at 7 o'clock. Speakers include Dr. George M. Lyon, pediatrician at the Memorial Hospital and St. Mary's Hospital, Huntington, W. Va. Doctor Lyon will speak in the afternoon on "Meningococcic Meningitis and Its Management" and in the evening on "Purulent Meningitides Due to Other than the Meningococcus." Dr. Harry Bakwin, Associate Professor of Pediatrics in the New York University, has accepted an invitation to give two talks. Dr. Charles F. McKhann, Associate Professor of Pediatrics at the Harvard Medical School and the Harvard School of Public Health, will speak in the afternoon on "Poliomyelitis" and in the evening on "Progress in the Control of Respiratory Infections."

Members of the medical profession are invited. For further information address Dr. W. W. Anderson, 478 Peachtree St., N. E., Atlanta, Ga.

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Dr. Gordon McSwain of Arcadia was recently elected president of the local Kiwanis Club.

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Out-of-town doctors who recently visited the headquarters of the Association in Jacksonville were: Drs. Leigh F. Robinson, Ft. Lauderdale; Lloyd J. Netto, West Palm Beach; A. M. Bidwell, Tampa, and O. N. Nelson, Bay Pines.

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## PAUL ESKEBERG

Dr. Paul Eskeberg, a recent addition to the medical profession of Miami, died in a Chicago hospital, August 31.

Dr. Eskeberg was born in Spokane, Washington, October 4, 1910. He attended Washington State College where he was a member of the Scabbard and Blade Society, and graduated with a B.S. degree in 1933. After entering Northwestern, he joined Alpha Kappa Kappa Medical Fraternity and graduated in medicine in 1937. He interned in Sacred Heart Hospital, Spokane, and moved to Miami after the completion of his internship. Although he had been in Miami only a short time, he formed the friendship of a large number of the doctors who were saddened when a diagnosis of leukemia was made. He had shown himself to be a very bright young man of good training and unusual ability, with a promise of a brilliant future.

He was married to Miss Musette Morrow on January 4, 1937, and she survives him. The Dade County Medical Society and the Florida Medical Association extend to her deepest sympathy.

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## COMPONENT COUNTY SOCIETIES

### DADE COUNTY MEDICAL SOCIETY

At the November 7 meeting of the Dade County Medical Society, the scientific program consisted of two papers: "Back Problems—Their Interpretation and Management" by Francis W. Glenn, discussed by Arthur H. Weiland and Ferdinand A. Vogt; and "Essential Hypertension—Present-day Concept of its Etiology" by Albert W. Wallace, discussed by E. Sterling Nichol and George D. Lilly.

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### DUVAL COUNTY MEDICAL SOCIETY

The November meeting of the Duval County Medical Society was held on the evening of the 7th at the Library of the State Board of Health Building. Dr. W. H. McCullagh was principal speaker, presenting a paper on "Myotonia Congenita," discussed by Dr. L. W. Holloway.

### ESCAMBIA COUNTY MEDICAL SOCIETY

The first meeting of the season was held by the Escambia County Medical Society on the evening of October 10 at the San Carlos Hotel, Pensacola, when the program for a venereal disease campaign was considered. A special committee proposed a plan of action, calling for setting up clinics in various centers, for treatment of indigent persons suffering from syphilis. The campaign was made possible by allocation of approximately \$5,000 by the federal and state governments to this county.

\* \* \*

### FRANKLIN-GULF COUNTY MEDICAL SOCIETY

The Franklin-Gulf County Medical Society held a meeting on the evening of September 28 at the Port Inn, Port St. Joe. Dr. L. J. Hanchett of the Bureau of Venereal Diseases of the Florida State Board of Health was guest speaker, illustrating his talk on "Syphilis" with motion pictures.

\* \* \*

### LEON-GADSDEN-LIBERTY-WAKULLA-

### JEFFERSON COUNTY MEDICAL SOCIETY

The quarterly meeting of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society was held on the afternoon of October 19 at Quincy. The following papers constituted the scientific program:

"Recent Advances in Tuberculosis"—A. J. Logie, Jacksonville; discussed by R. F. Godard, Quincy.

"Modern Conception of Epilepsy"—F. M. Hewson, Chattahoochee, discussed by W. G. Miles, Chattahoochee.

"Typhus Fever"—M. W. Williams, Camilla, Ga., discussed by G. H. Garmany, Havana.

"Undulant Fever in Children: Its Diagnosis"—Helen W. Bellhouse, Thomasville, Ga., discussed by Edward Annis, Tallahassee.

"Case Report"—T. W. Griffin, Quincy, discussed by G. W. Brown, Tallahassee.

At the business meeting which followed the scientific session, the following officers were elected: president—F. T. Holland, Tallahassee; vice president, Ralph E. Stevens, Chattahoochee, and secretary—B. A. Wilkinson (re-elected).

At 6:30 the doctors and their ladies enjoyed a barbecue at the Sawano Country Club.

PASCO-HERNANDO-CITRUS COUNTY  
MEDICAL SOCIETY

Dr. J. T. Bradshaw of San Antonio entertained the Pasco-Hernando-Citrus County Medical Society at the Orange Hotel in Dade City, October 12, 1939.

A full course chicken dinner was served and greatly enjoyed by the members present. Following the dinner the scientific meeting was held in the parlor of the hotel.

The minutes of the last meeting were read and adopted.

Interesting clinical case reports were given and discussed by those present.

Dr. S. C. Harvard invited the Society to meet with him in Brooksville in November.

Those present were: Drs. J. T. Bradshaw, E. W. Brown, C. L. Carter, G. R. Creekmore, S. C. Harvard, W. W. Jones, D. B. Manley, R. D. Sistrunk, and W. H. Walters.

\* \* \*

## PINELLAS COUNTY MEDICAL SOCIETY

The Pinellas County Medical Society met at the Suwannee Hotel, St. Petersburg, October 5, 1939. Dr. Earl C. MacCordy presided. The minutes of the previous meeting were read and approved. The financial report was read and approved. The journal had been earlier audited by the president.

The following were elected members: Dr. Simpson Daniel Puttler, St. Petersburg, and Dr. Simeon Mayo Wrenn, St. Petersburg.

The following were elected officers of the Society: President-elect, Dr. N. W. Gable, Jr.; 1st Vice President, Dr. M. A. Nickle; 2nd Vice President, Dr. H. D. Solomon; Secretary-Treasurer, Dr. W. C. McConnell; Censors, Dr. F. H. Langley, and Dr. H. E. Winchester.

Dr. MacCordy gave his farewell address and presented the gavel of authority to Dr. John A. Herring who then became President. Dr. Herring thanked the organization and asked cooperation. He then presented the past president's plaque to Dr. Earl C. MacCordy.

The matter of telephone directory roster was presented. It was stated that the Company had increased its rate per column from \$72 to \$90 a year and that three columns would be needed. Dr. O. O. Feaster moved, and Dr. A. L. Mills seconded the motion, to

continue the insertion at the increased rate, the prorated fee to be \$3.75 each.

Dr. G. M. Lochner asked about the \$125 spent with the lawyer and the action of the committee was explained to him. Doctor MacCordy then talked about the drive for two iron lungs for St. Petersburg. Dr. R. D. Murphy moved, and the motion was seconded, that the Society donate \$100 to the fund. Doctor Feaster moved to amend the motion that if \$100 be given to St. Petersburg that \$50 be given to Clearwater when that city had its drive for an iron lung. This was seconded. The motion as amended was carried in the usual way. (It is needless to say that it hurt the Scotch secretary to give one-third of the annual income at one sitting.)

The matter of minimum fee schedule was referred to the Medical Economics Committee of which Doctor Nickle is chairman, the report to be presented at the next meeting.

Attention was called to the fact that newly elected officers automatically become chairmen of committees and that they appoint their associates. They were referred to Article IX, By-Laws.

The meeting adjourned at 8:30 p. m.

On the evening of October 20, the Academy Program of the Pinellas County Medical Society was held, and the following papers presented:

"Osteomyelitis"—C. L. Farrington.

"Pulmonary Tuberculosis"—A. S. Anderson.

\* \* \*

## POLK COUNTY MEDICAL SOCIETY

The Polk County Medical Society, Inc., succeeding the Polk County Medical Society, held its first meeting under the new set-up at the Civic Center, Bartow, on the evening of September 13 with about 35 members present. Acceptance of the new By-Laws and Charter was unanimous after Dr. J. R. Boulware, secretary, read them.

Dr. John F. Wilson, Lakeland, president, conducted the business meeting, at which Dr. Sam Clark, Lakeland, and Dr. Ivan W. Gessler, Winter Haven, new Polk County doctors, were introduced.

Dr. J. C. Vinson of Tampa was principal speaker.





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## ABSTRACT DEPARTMENT

*Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.*

**A Deficient Homologous Immunity Following Simultaneous Inoculation with Two Strains of *Plasmodium Vivax*, BOYD, MARK F.; KUPPER, W. H.; and MATTHEWS, CHOICE B., Tallahassee, *Am. J. Trop. Med.* 18: 521-524 (Sept.), 1938.**

When a patient has been inoculated with *Plasmodium vivax*, he develops resistance to reinfection by that same strain of vivax. This immunity is manifested by an ability to tolerate densities of the parasite that would result in clinical symptoms in a susceptible person, and by an acquired ability of the body to destroy and remove parasites.

If, however, a patient is inoculated simultaneously with two strains of *Plasmodium vivax* by an intravenous injection containing approximately equal numbers of trophozoites of each strain, there seems to develop an altered immunity. If such an inoculated subject is now successively inoculated with trophozoites of each strain previously injected, he may develop short clinical attacks, or show increased parasitic densities. It would seem as though the simultaneous infection with two strains delays the development of an adequate homologous immunity to either strain; in effect the immunity produced (for some immunity is present) is heterologous.

**Enlargement of Heart in Infants and Young Children, KUGEL, M. A., Miami, *Am. Heart J.* 17: 602 (May), 1939.**

Kugel points out that only in recent years has it been demonstrated that in many cases what was formerly called "idiopathic hypertrophy" of the heart was in reality associated with congenital malformations, rheumatic fever, glycogen-storage disease, myocardial degeneration and fibrosis. Cases of dilatation and hypertrophy of the heart, associated with myocardial degeneration and fibrosis, constitute the majority of those formerly included under the title of "idiopathic hypertrophy." The term "congenital idiopathic hypertrophy" of the heart is not only un-

desirable but also confusing. In most instances the cause or nature of the enlargement of the heart in an infant or young child can be determined if the various criteria or diseases are kept in mind.

The author states that a study of the cases even as reported in the literature revealed that most of them were not genuine examples of congenital idiopathic hypertrophy of the heart, since either myocardial disease or other factors were found at postmortem examination which could have had a casual relationship to the cardiac enlargement. In 1933 Kugel and Stoloff described seven cases of unusual enlargement of the heart in infants and young children which heretofore might have been regarded as examples of idiopathic hypertrophy. In all instances the clinical picture and the pathologic changes in the myocardium were similar.

The chief features of this condition are enlargement of the heart without known cause, an afebrile course, the sudden onset of symptoms, dyspnea and cyanosis and the lack of signs or history suggestive of congenital heart disease, rheumatic fever, diphtheria, infections, anemia or metabolic disturbances. Further investigation of fresh pathologic material with chemical examinations in an additional case confirmed the original impression that this form of cardiomegaly was different from von Gierke's disease and other types of cardiac enlargement.

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NEREAL DISEASES,  
Vol. 23, No. 2,  
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#### TETANUS IMMUNIZATION

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Rogers (*Bull. New York Acad. Med.*, 15: 553, August, 1939) has suggested that active tetanus immunization should be given to those who are sensitive to horse serum, to asthmatic patients and other allergic individuals if they are in occupations or indulge in avocations which carry with them danger of injury. He includes in an optional group children, especially those living in the country or those who ride, and non-allergic individuals engaged in hazardous occupations or avocations.

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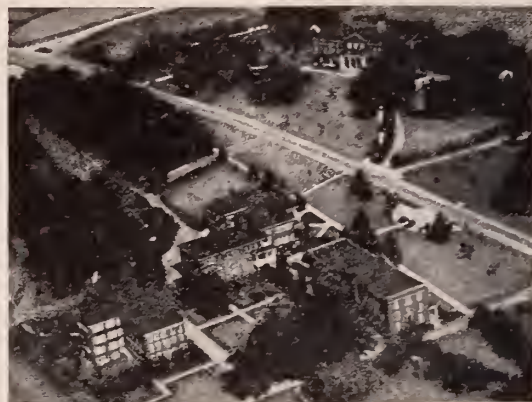


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## AUXILIARY DISTRICT CONFERENCE

The officers of the Auxiliary were pleased with the increase in the number of ladies attending the Southeast District meeting. There were 28 ladies registered at the West Palm Beach meeting, which is the highest record for any of the district meetings so far. The West Palm Beach ladies proved themselves to be royal hostesses.

After registering at the Palm Beach Yacht Club and securing badges and programs, the ladies were taken by motorcade to the Sun and Surf Club on the beach. After a short business meeting the ladies were entertained as guests of the members of this exclusive club. Every facility was available for their pleasure and comfort. Bridge, swimming, backgammon, etc., were enjoyed by those present.

At 5:00 p. m. the ladies were escorted to the home of Mrs. F. K. Herpel, where cocktails were served. The group then returned to the Palm Beach Yacht Club where they joined the doctors for a buffet supper.

In the absence of the District Chairman, Mrs. H. A. Leavitt of Miami, Mrs. Lloyd J. Netto of West Palm Beach presided at the business meeting, introducing Mrs. L. C. Ingram, your State President, and she in turn introduced the State Hygeia Chairman, Mrs. Leigh Robinson and Mrs. J. W. McMurray, the State Exhibit Chairman, both of Ft. Lauderdale.

Your President stressed the National program as outlined by Mrs. Rollo Packard of

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Chicago and the State's program as outlined by the Board and the Advisory Committee of the Medical Association, and also urged their correlation and suggested a further correlation of the work in their District by organizing themselves into a District Auxiliary. This met with favor and the following officers were elected: President, Mrs. H. A. Leavitt, Miami; Vice President, Mrs. Lloyd Netto, West Palm Beach; Secretary, Mrs. W. E. Bippus, West Palm Beach; Treasurer, Mrs. George Warren, Key West.

Your president feels that this is a step in advance as other states have District Auxiliaries and have found them a great help to the state organization.

MRS. L. C. INGRAM, *State President*.

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\* \* \*

#### MEDICAL AUXILIARY EXHIBIT

This is the beginning of the year for all of us in our Medical Auxiliary work. Most of us are meeting to discuss our program and objectives for the year. May I suggest that while you are doing this, you plan for some special exhibit for the State Medical Auxiliary meeting next summer. From these we will select several that best typify the work being carried on by the County Auxiliaries and these will be sent to the National Medical Auxiliary meeting. We are all anxious to make a good showing there in 1940 and we would appreciate any clever and original ideas along these lines very much.

I am listing below some suggestions that may give you an idea: Scrap books, A State flag, posters on Auxiliary objectives, spot maps of Auxiliary activities, posters and information on Health Days, maps of the State showing organized Medical Auxiliaries, layettes and O. B. packs, soap carvings, biographies of our State's eminent physicians,



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\* \* \*

Mrs. L. C. Ingram, State president of the Woman's Auxiliary to the Florida Medical Association, and her daughter-in-law, Mrs. Hollis Ingram, Orange County president of the Woman's Auxiliary, were joint hostesses to the Orange County Auxiliary at the home of Mrs. L. C. Ingram on Tuesday, September 26.

Most of the members were present and enthusiastically discussed their plans for the coming year. Besides taking up the projects outlined by the State Association they hope to promote several local projects.

\* \* \*

The many friends of Mrs. J. E. Maines of Lake Butler will regret to learn of her death, on October 10, 1939.

### BOOKS RECEIVED

**MEDICOLEGAL PHASES OF OCCUPATIONAL DISEASES: AN OUTLINE OF THEORY AND PRACTICE.** By C. O. SAPPINGTON, A.B., M.D., Dr. P. H., Consultant, Occupational Diseases and Industrial Hygiene. In the Preface, the author states: "Any critical analysis of a medicolegal problem in occupational disease involves a consideration of all the aspects of the occupational disease problem as a whole, including the measurement and evaluation of industrial exposures; interpretation and application of information relating to physical examinations, diagnoses, clinical laboratory work and x-ray findings; the correlation of industrial and medical information in terms of cause-and-effect relationships; occupational disease legislation; case decisions of damage suits; commission hearings, and review decisions; and insurance coverage. The complicated ramifications of the problems relative to occupational diseases are thus evident." Written in non-technical language, the book is divided into five parts: (1) Industrial, (2) Insurance, (3) Medical, (4) Legal, (5) Appendix. Twenty-nine tables give valuable information. Cloth, Pp. 405; illustrated. Chicago: Industrial Health Book Company.

\* \* \*

**FUNCTIONAL DISORDERS OF THE FOOT: THEIR DIAGNOSIS AND TREATMENT.** By FRANK D. DICKSON, M. D., and REX L. DIVELEY, M. D., Orthopedic Surgeons, St. Luke's, Kansas City General, and Wheatley Hospitals, Kansas City, Mo.; and Providence Hospital, Kansas City, Kansas. This comprehensive volume, written in a concise manner, covers in its 18 chapters: Evolutionary Development of the Human Foot, Anatomy, Physiology, Primary Causes of Foot Imbalance, Examination, The Foot of Childhood, Foot Imbalance in Childhood, Foot Imbalance in Adolescence, Foot Imbalance in the Adult, Foot Apparel, Hallux, Affections of the Nails, Affections of the Skin, Affections of the Tarsal and Metatarsal Bones, Affections of the Heel, Constitutional Diseases Affecting the Feet, Foot Strapping, and Foot Exercises. Cloth. Pp. 305, with 202 illustrations. Price \$5.00. Philadelphia: J. B. Lippincott Co., 1939.




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## COMPONENT SOCIETIES BY DISTRICTS — FLORIDA MEDICAL ASSOCIATION

Districts	COUNTY SOCIETIES	PRESIDENT	SECRETARY	MEETING DATE	COUNCILOR and Counties Not Included in First Column	Members	
						Total	Paid
Northwest District (A) Marion July 20, 1939	Bay	Donald S. Fraser, M.D. Panama City	William C. Roberts, M.D. Panama City		A-1-'40 Carol C. Webb, M.D. Pensacola	12	100%
	Escambia	L. C. Fisher, Jr., M.D. 816 N. Palafox St. Pensacola	J. M. Hoffman, M.D. 1221 E. DeSoto St. Pensacola	2nd Tuesday 8:00 P. M.		44	40
	Walton-Okaloosa	A. G. Williams, M.D. Lakewood	R. B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P. M.		6	100%
	Washington-Holmes	W. D. Ramsey, M.D. Noma	L. H. Paul, M.D. Bonifay		Santa Rosa	8	7
	Franklin-Gulf	Chapman Dykes, M.D. Carrabelle	A. L. Ward, M.D. Port St. Joe	3rd Thursday	A-2-'41 B. A. Wilkinson, M.D. Tallahassee	6	100%
	Jackson	C. J. Price, M.D. Alford	R. N. Joyner, M.D. Marianna	2nd Tuesday 7:30 P. M.		13	12
	Leon-Gadsden-Liberty-Wakulla-Jefferson	Francis T. Holland, M.D. 208 Midyette-Moor Bldg. Tallahassee	B. A. Wilkinson, M.D. Telephone Bldg. Tallahassee	Quarterly 3:00 P. M.	Calhoun	39	35
North Central District (B) Ocala October 26, 1939	Columbia	W. M. Ives, M.D. 132 N. Marion St. Lake City	Harry S. Howell, M.D. Blanche Hotel Annex Lake City	1st Monday 7:30 P. M.	B-3-'41 W. S. Nichols, M.D. Lake City	21	16
	Madison	E. Long, M.D. Madison	A. F. Harrison, M.D. Madison			3	2
	Taylor	Geo. H. Warren, M.D. Perry	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P. M.	Baker-Dixie-Hamilton-Lafayette-Suwannee	8	6
	Alachua	J. E. Malnes, Jr., M.D. 433 E. Main St. N. Gainesville	J. Maxey Dell, Jr., M.D. 333 W. Main St., S. Gainesville	2nd Friday 7:30 P. M.	B-4-'40 James L. Strange, M.D. McIntosh	29	24
	Marion	Carl S. Lytle, M.D. Dunnellon	R. C. Cumming, M.D. Commercial Bank Bldg. Ocala	3rd Thursday 12:30 P. M.		23	100%
	Pasco-Hernando-Citrus	Claude L. Carter, M.D. Inverness	G. R. Creekmore, M.D. Brooksville	2nd Thursday 7:00 P. M.		15	100%
	Sumter		A. B. Albritton, M.D. (Acting Secretary) Wildwood	2nd Tuesday	Bradford-Gilchrist-Levy-Union	3	2
N. E. District (C) Palatka September 14, 1939	Duval	Thomas E. Buckman, M.D. 1022 Park St. Jacksonville	Lauren M. Sompayrac, M.D. 459 St. James Bldg. Jacksonville	1st Tuesday 8:15 P. M.	C-5-'41 R. B. McIver, M.D. Jacksonville	175	173
	St. Johns	R. D. Harris, M.D. St. Augustine	G. Walter Potter, M.D. East Coast Hospital St. Augustine	3rd Tuesday 8:30 P. M.	Clay-Nassau	10	100%
	Putnam	Edward W. Ford, M.D. Crescent City	C. M. Knight, M.D. Palatka	2nd Tuesday in Feb., April, June, Aug., Oct., Dec. 7:00 P. M.	C-6-'40 George M. Green, M.D. Daytona Beach	11	100%
	Volusia	Maximilian Stern, M.D. Box 5098 Daytona Beach	R. L. Miller, M.D. 258 1/4 S. Beach St. Daytona Beach	2nd Tuesday 7:30 P. M.	Flagler	41	40
Southwest District (D) Lakeland September 28, 1939	Hillsborough	J. W. Alsobrook, M.D. 120 N. Collins St. Plant City	James S. Grable, M. D. 811 Citizens Bank Bldg. Tampa	1st Tuesday 8:00 P. M.	D-7-'41 W. C. McConnell, M.D. St. Petersburg	113	101
	Manatee	S. G. Hollingsworth, M.D. 451 12th St. Bradenton	M. M. Harrison, M.D. Professional Bldg. Bradenton	3rd Tuesday 7:00 P. M.		14	100%
	Pinellas	John A. Herring, M.D. 259 Third St., No. St. Petersburg	W. C. McConnell, M.D. 1001 First Federal Bldg. St. Petersburg	1st and 3rd Fridays 6:30 P. M.		95	100%
	Sarasota	T. W. Taylor, M.D. Professional Bldg. Sarasota	Stanley T. Martin, M.D. Sarasota	2nd Tuesday 8:30 P. M.		17	14
	DeSoto-Hardee-Highlands-Charlotte-Glades	Ben D. Spears, M.D. Wauchula	Howard W. Weems, M.D. 22 Oak St. Sebring	2nd Tuesday 8:00 P. M.	D-8-40 Herman Watson, M.D. Lakeland	20	100%
	Lee	C. Gordon Merrick, M.D. 28 Leon Bldg. Fort Myers	H. L. Allan, M.D. 312 Pythian Bldg. Fort Myers	3rd Friday 7:30 P. M.		14	13
	Polk	John F. Wilson, Jr., M.D. Box 254 Lakeland	J. R. Boulware, Jr., M.D. P. O. Box 367 Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P. M.	Collier-Hendry	61	100%
South Central District (E) Sanford November 9, 1939	Brevard	W. J. Creel, M.D. Eau Gallie	I. K. Hicks, M.D. Melbourne	3rd Tuesday	E-9-'40 W. C. Page, M.D. Cocoa	11	9
	Lake	W. G. DeVane, M.D. Groveland	Oliver Emerson, M.D. Tavares	1st Thursday 12:30 P. M.		18	16
	Orange	C. D. Hoffmann, M.D. 120 E. Robinson St. Orlando	Fred Mathers, M.D. Box 53 Orlando	3rd Wednesday 8:30 P. M.		81	80
	Seminole	Thomas F. McDaniel, M.D. Seminole County Bank Bldg. Sanford	Douglas G. Scott, M.D. 212 N. Park Ave. Sanford	2nd Monday 7:00 P. M.	Osceola	12	100%
	St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D. Box 942 Stuart	Adrian M. Sample, M.D. Ft. Pierce	3rd Thursday 8:00 P. M.	E-10-'41 A. M. Sample, M.D. Ft. Pierce	17	100%
	Broward	R. L. Elliston, M.D. 814 Sweet Bldg. Ft. Lauderdale	Oliver C. Brown, M.D. 915 Sweet Bldg. Fort Lauderdale	4th Wednesday 8:00 P. M.	F-11-'40 Lloyd J. Netto, M.D. West Palm Beach	34	100%
S. E. District (F) West Palm Beach October 12, 1939	Palm Beach	Gaylord Lewis, M.D. 916 Harvey Bldg. W. Palm Beach	C. Jennings Derrick, M.D. Box 574 W. Palm Beach	4th Monday 8:00 P. M.		59	100%
	Dade	M. Jay Filipe, M.D. 305 Huntington Bldg. Miami	Franz Stewart, M.D. 1105 Huntington Bldg. Miami	1st Tuesday 8:30 P. M.	F-12-'41 Kenneth Phillips, M.D. Miami	297	271
	Monroe	Harry C. Galey, M.D. 532 Fleming St. Key West	W. R. Warren, M.D. 511 Eaton St. Key West	1st Sunday 9:00 P. M.		4	100%



STATE AND SECTIONAL MEETINGS

SOCIETY	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association.....	Leigh F. Robinson, Ft. Lauderdale	Shaler Richardson, Jacksonville...	Tampa, Apr. 29, 30 & May 1, 1940
Florida Medical Districts:			
A—Northwest .....	B. A. Wilkinson, Tallahassee.....	Stewart Thompson, Jacksonville...	Pensacola, 1940
B—North Central .....	William S. Nichols, Lake City...	" " "	Lake City, 1940
C—Northeast .....	Robt. B. McIver, Jacksonville.....	" " "	Daytona Beach, 1940
D—Southwest .....	W. C. McConnell, St. Petersburg.	" " "	Dunedin, 1940
E—South Central .....	A. M. Sample, Ft. Pierce.....	" " "	Ft. Pierce, 1940
F—Southeast .....	Kenneth Phillips, Miami .....	" " "	Key West, 1940
Alabama Medical Association.....	M. S. Davie, Dothan.....	D. L. Cannon, Montgomery.....	Birmingham, April 16-18, 1940
Georgia, Medical Assn. of.....	W. H. Myers, Savannah.....	E. D. Shanks, Atlanta .....	Savannah, April 23-26, 1940
Florida—			
State Dental Association.....	E. B. Penn, Miami.....	E. C. Lunsford, Miami.....	St. Petersburg, Nov., 1940
Soc. of Derm. and Syph.....	Elmo D. French, Miami.....	Lauren M. Sompayrac, Jacksonville	Jacksonville, Nov. 1939
East Coast Medical Association.	I. M. Hay, Melbourne.....	J. S. Stewart, Miami.....	Miami, 1940
State Hospital Association.....	J. H. Therrell, Chattahoochee.....	Mr. Fred M. Walker, Jacksonville.	Mississippi, March, 1940
Assn. of Industrial Surgeons.....	Harrison A. Walker, Miami Beach	A. M. Bidwell, Tampa.....	Tampa, Apr. 29, 1940
Internists' Society.....	Norval M. Marr, St. Petersburg...	Kenneth Phillips, Miami.....	Tampa, Apr. 29, 1940
Medical Postgraduate Course...	Turner Z. Cason, Jacksonville....	Chairman	Jacksonville, 1940
Soc. of Ophthal. & Otol.....	S. B. Forbes, Tampa.....	Temporary Chairman	Tampa, Apr. 29, 1940
State Nurses Association.....	Mrs. Inez Nelson, Orlando.....	Mrs. Phyllis Leonard, St. Augustine	Lakeland, Nov. 6-8, 1939
Pediatric Society .....	Warren W. Quillian, Coral Gables	G. N. Leonard, Miami Beach.....	Tampa, 1940
Pharmaceutical Association .....	Mr. S. F. Harris, Jacksonville...	Mr. A. W. Morrison, Miami.....	Tampa, May, 1940
Public Health Association .....	Mr. S. D. Macready, W. P. Beach	E. M. L'Engle, Jacksonville.....	Jacksonville, Dec. 7-9, 1939
Radiological Society .....	H. B. McEuen, Jacksonville.....	J. N. Moore, Ocala .....	Tampa, Apr. 29, 1940
Railway Surgeons' Association...	H. D. Clark, Ft. Pierce.....	W. C. Page, Cocoa.....	Tampa, Apr. 28, 1940
Tuberculosis & Health Assn....	Mr. G. E. Therry, W. Palm Beach	Mrs. May Pynchon, Jacksonville...	Spring, 1940
Chattahoochee Valley Med. Assn...	M. Y. Dabney, Birmingham.....	Frank K. Boland, Atlanta.....	Albany, Ga., July 9-11, 1940
Gulf Coast Clinical Society.....	J. H. Dodson, Mobile.....	C. C. Rouse, Mobile.....	Mobile, Oct. 26-27, 1939
Southeastern Derm. Assn.....	Jack Jones, Atlanta.....	Howard Hailey, Atlanta.....	Atlanta, Ga., Sept. 1, 1940
Southeastern Surgical Congress...	R. L. Sanders, Memphis.....	B. T. Beasley, Atlanta.....	Birmingham, Mar. 11-13, 1940
Southern Medical Association.....	W. E. Vest, Huntington, W. Va.	Mr. C. P. Loran, Birmingham....	Memphis, Nov. 21-24, 1939
Suwannee River Medical Society...	T. H. Bates, Lake City.....	H. S. Howell, Lake City.....	

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The swaddled infant pictured at right is one of the famous works in terra cotta exquisitely modeled by the fifteenth century Italian sculptor, Andrea della Robbia. In that day infants were bandaged from birth to preserve the symmetry of their bodies, but still the gibbous spine and distorted limbs of severe rickets often made their appearance.



*A bambino from the Foundling Hospital, Florence, Italy,—A. della Robbia*

Glisson, writing in 1671, described an ingenious use of swaddling bands — "first crossing the Brest and coming under the Armpits, then about the Head and under the Chin and then receiving the hands by two handles, so that it is a pleasure to see the Child hanging pendulous in the Air . . . This kind of Exercise . . . helpeth to restore the crooked Bones. . . ."

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VOLUME XXVI  
No. 6

Jacksonville, Florida, December, 1939

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## NEXT SESSIONS

American Medical Association, New York, June 10-14, 1940  
Florida Medical Association, Tampa, April 29, 30, and May 1, 1940  
Southern Medical Association, Memphis, November 21-24, 1939

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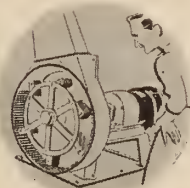


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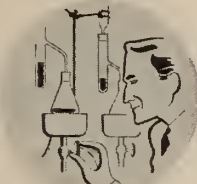


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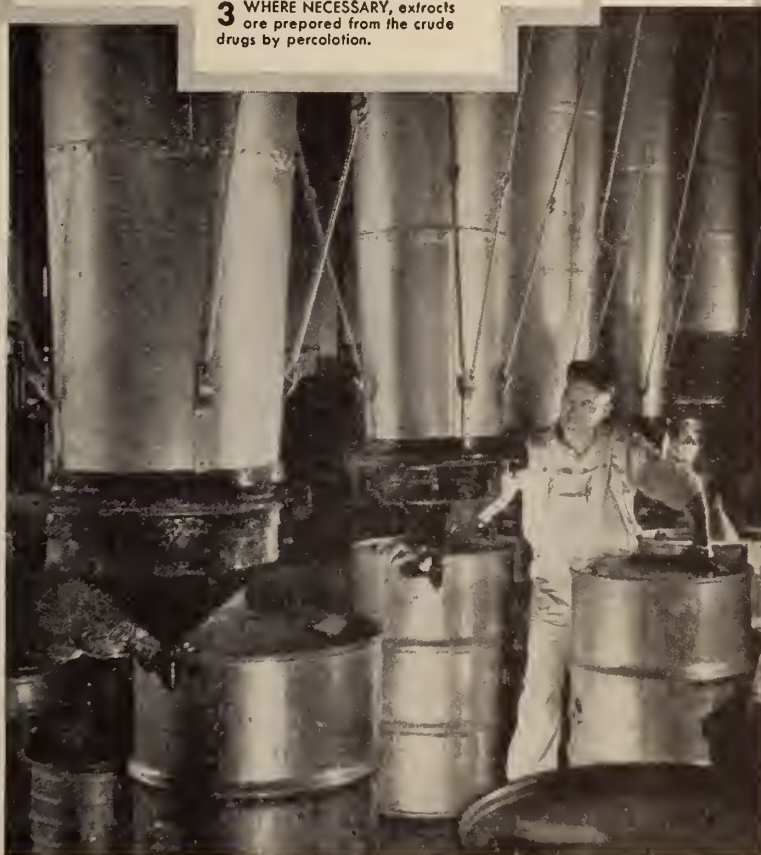
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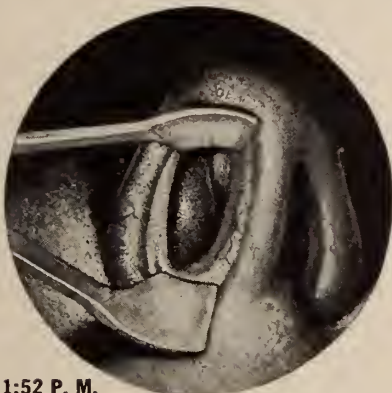
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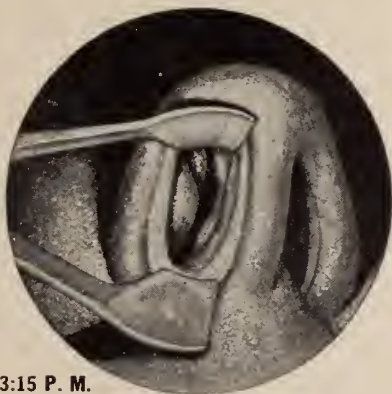
Swollen turbinates and septum. Two inhalations from 'benzedrine Inhaler.'



2:01 P. M.

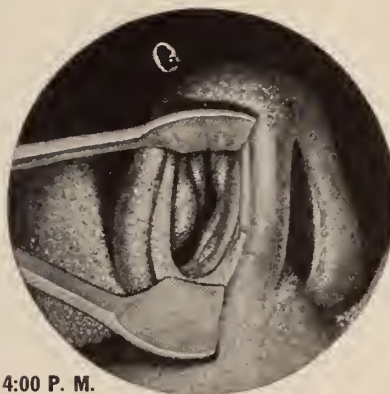
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## AN EVALUATION OF THE MORE COMMON SERODIAGNOSTIC TESTS OF SYPHILIS

JAMES N. PATTERSON, M. D.

Jacksonville

It is with considerable trepidation that I attempt to discuss in such a short space of time a problem so controversial in nature that it has had volumes written about it and one in which the best minds in scientific research are not in accord. Before attempting an evaluation of the more common serodiagnostic tests, I would like to review briefly the progress of syphilis in the body along with the reactions of the body against the causative organism. Also I wish to discuss very briefly the principles involved in the two different kinds of serodiagnostic tests, namely, the complement fixation and flocculation tests.

From the viewpoint of a pathologist, syphilis is divided into three stages:

1. Primary stage—Hard chancre.
2. Secondary stage—Cutaneous lesions; mucous patches; condyloma lata; generalized lymphadenopathy; periostitis; nervous system involvement; iritis.
3. Tertiary stage—gunma; diffuse lesions.

These different stages of the disease are due to different sets of tissue developing hypersensitiveness. The primary lesion or hard chancre does not appear at the site of inoculation until about a month after contact even though the spirochetes are widely disseminated throughout the body within a few hours after inoculation. It is at first a hard nodule later becoming ulcerated and in which enormous numbers of spirochetes are present. Less than 50 per cent of serodiagnostic tests are positive in the early stage of the chancre.

After the disappearance of the primary lesion there is a latent period during which all is seemingly well. This reveals an excellent illustration of the difference between infection and clinical disease for all the tissues

are infected and yet there are no signs of the disease. At the end of two or three months after infection the tissues of ectodermal origin develop the power to react and lesions recur in the skin, mucous membrane and central nervous system. These lesions last, as a rule, for a month but may recur at the same place later on. This recurrence is thought to be due to a loss of local immunity and the multiplication of the surviving spirochetes. The lesions of the secondary stage are teeming with spirochetes.

Following the subsidence of the secondary lesions another latent period occurs which lasts anywhere from a year to fifteen or twenty years. The tertiary lesions occur in two main types—one, the gunma, a localized process in which necrosis is evident and the other a diffuse fibrotic process with very little necrosis. These lesions contain very few spirochetes and so are but slightly infectious.

The substance formed in the body of a person affected with syphilis and found in the serum and other fluid is called reagin and is pronounced in a variety of ways by many different workers in the field. There is still much controversy as to its exact nature but some facts about it are pretty well established. Like antibodies in general, reagin is actually a protein and is found only in the globulin fraction of the serum protein. It is carried down with this fraction upon half-saturation with ammonium sulfate. The albumin fraction of syphilitic serum is always negative. It is thought by most workers that the reagin contained in syphilitic serum is deposited on the surface of the lipoidal particles of the antigen suspension. This, as in the case of other antibodies, probably causes the aggregation of the antigen particles by acting as a sensitizing film of protein in the presence of an electrolyte. In other words, it is thought that syphilitic sera (reagin globulin) forms a water insoluble (hydrophobic) sensitizing film around the lipoidal particles and this allows for flocculation by an electrolyte. Normal serum protein adsorbed by antigen particles forms a water soluble (hydrophilic) protecting film which is not flocculated by an electrolyte and the lipoidal particles remain discrete.

It has been clearly demonstrated by many

From the Bureau of Laboratories, Florida State Board of Health.

Read before the Sixty-sixth Annual Meeting of the Florida Medical Association, held at Daytona Beach, May 1, 2 and 3, 1939.



lines of approach that the same film of reagin globulin is responsible for both flocculation and complement fixation. The principle of the flocculation test, as just stated, is that the sensitized particles of antigen are agglutinated in the presence of an electrolyte, sodium chloride, which lowers the surface tension, allowing the individual particles to adhere to one another and thus produce clumping visible to the naked eye. In the complement fixation test the reagin globulin coats the lipoidal particles and fixes the complement so that when the indicator (sheep cells) and their amboceptors (antibodies) are added, there is no complement to combine with them and hence no hemolysis takes place. In other words, the two tests provide different indicators for the same substance, globulin reagin.










The first flocculation tests which were adequately sensitive and specific enough to be of diagnostic importance were the Sachs-Georgi, Meinicke and Vernes' tests. These tests were developed before 1920. In general, all of them involved the use of a dilute transparent non-sensitized antigen and the precipitate formed slowly so that these tests may be classified as slow precipitation types of flocculation reaction.

From 1920 to 1930 a series of flocculation techniques were developed and were known as rapid flocculation or rapid opacification tests. In these tests there is a high concentration of lipid in the antigen suspension. Of the rapid flocculation procedures the Kahn test is best known and most widely used. It owes its sensitivity not only to a highly concentrated and purified antigen but to carefully determined optimum conditions for the aggregation of the particles in syphilitic serum. Other tests of the same general type were those of Bruck, Dold, Hecht, Sachs and Witebsky, Scaltritti and Weiss.

Within the last few years a third type of flocculation reaction has been developed. The antigen suspension in this type of test is similar to the one used in the rapid flocculation type but is denser due either to the larger average size or the larger number of individual antigen particles. In negative serum these large particles redisperse but in positive serum they form large clumps with a clearing of the serum. These tests, spoken of as clarification type of flocculation test, include the

Müller, Hinton, Poeplau, Kline, Meinicke and Eagle. (Fig. 1 from Eagle's "The Laboratory Diagnosis of Syphilis," copyright, C. V. Mosby, publishers).

FIG. 1  
DIAGRAMMATIC REPRESENTATION OF THE DEVELOPMENT OF FLOCCULATION TECHNIC

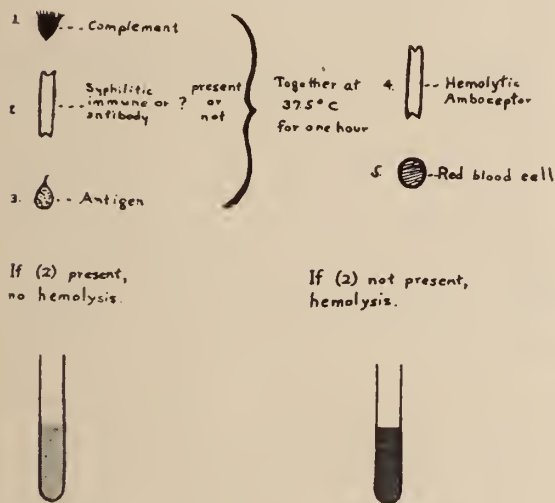
Type of test	Appearance of Tests		
	Macroscopic		Microscopic appearance of positive reaction
	Positive	Negative	
Slow precipitation 1910-1920	Finely granular sediment 	Homogeneous translucent 	
Rapid Opacification 1920-1930	Diffusely granular 	Homogeneous translucent 	
Clarification 1926-	A few large clumps floating in clear fluid 	Homogeneous, but diffusely opalescent or opaque 	

The question arises as to whether a complement fixation test or a flocculation test is to be preferred. The ideal arrangement would be to do a reliable test of each kind, for occasionally we find a syphilitic serum that will react positive to a flocculation test and negative to a complement fixation test, while another positive serum may give the reverse picture. However, usually a syphilitic sera reacts equally well to a properly performed reliable flocculation or complement fixation test. The accurate performance of the particular test, and this should be emphasized, is more important than any particular reliable test employed. In other words, a properly performed Kahn test is far superior to an improperly performed complement fixation test and the reverse is equally true.

Simplicity of the technique of the flocculation tests, as compared with the complement fixation test, is so great that they bid fair eventually to replace the latter reaction. In the flocculation test only two reagents are required, antigen and serum, while in the complement fixation five reagents are required: namely, complement from fresh guinea pig serum, sheep cell antigen, sheep cell amboceptors from rabbit sera sensitized to sheep cells, antigen and serum. There are many variable factors in a Wassermann reaction, such

as cell fragility, complement deterioration and anticomplementary activity of the serum which have no bearing on a flocculation test. However, although the flocculation test is much easier to perform than a complement fixation test, it is much more difficult to read. A technician can learn very quickly to read the complement fixation test, for the difference between the positive, negative and doubtful tubes are quite marked. (Fig. 2). In the

FIG. 2



flocculation test we do not have an indicator that gives such striking differences in appearance, so that it is considerably harder to learn to read a flocculation type of test. (Fig. 3. From Kahn's "The Kahn Test, a Practical Guide," copyright, Williams & Wilkins Co., publishers).

This difficulty has been partly eliminated by the newer clarification tests, as the Eagle and Hinton tests. (See Fig. 1).

The fallacy of "percentage agreement" as a means of comparing the value of two different techniques is shown by Chart 1. (From Eagles' "The Diagnosis of Syphilis," through courtesy of C. V. Mosby Co., publishers.) It amply illustrates how figures can be juggled to suit the occasion. In a comparison of the two tests A and B on syphilitic sera, test A has a 90 per cent sensitivity which is excellent, while test B has 50 per cent sensitivity. Test A also has only 0.1 per cent false positives, while test B has 5 per cent false positives. Now comparing the results of these two tests

in a thousand tests on a general hospital population containing 3 per cent syphilitic patients, we find an absolute agreement in 93.8 per cent, which on the surface looks good. However, if we perform these two tests on one thousand syphilitic patients we find an altogether different picture—an agreement in only 61.4 per cent.

The fairest method of comparing or evalu-

FIG. 3



A., Strong Reaction; B., Weaker Reaction; C., Negative Reaction. To read weak reactions, each tube must be lifted from the rack and examined individually.

CHART 1

The Fallacy of "Percentage Agreement" as a Means of Comparing the Value of Two Technics.

	Test A	Test B
Sensitivity in syphilitic sera . . . . .	90%	50%
False reactions in nonsyphilitic sera	0.1%	5%

a.

Results Obtained in 1,000 Tests on a General Hospital Population Containing 3 per Cent Syphilitic Patients

Tests A and B Both Positive	Tests A and B Both Negative	Test A+ Test B—	Test A— Test B+
14 1.4%	924 92.4%	13 1.3%	49 4.9%

Absolute agreement in 93.8%

b.

Results Obtained in 1,000 Tests on Syphilitic Patients

Tests A and B Both Positive	Tests A and B Both Negative	Test A+ Test B—	Test A— Test B+
520 52%	94 9.4%	381 38.1%	5 0.5%

Absolute agreement in 61.4%



ating the different tests is to run them against the same known syphilitic sera and sera from individuals presumably non-syphilitic. Such tests have been conducted by the League of Nations Conferences and by the U. S. Public Health Service, with the cooperation of the American Society of Clinical Pathologists.

CHART 2  
SERODIAGNOSTIC TESTS FOR SYPHILIS  
Results in Evaluation of Serodiagnostic Tests for Syphilis\*

SEROLOGIST	Blood Tests		Spinal Fluid Tests	
	Percent- age of false positive reports in pre- sumably non- syphilitic cases (468)	Percent- age of positive reports in syphilitic cases (415)	Percent- age of false positive reports in pre- sumably non- syphilitic cases (110)	Percent- age of positive reports in syphilitic cases (110)
Brem <sup>2</sup>	0.7	70.5	1.0	89.6
Eagle	1.1	84.1	0	78.0
Hinton <sup>1</sup>	1.7	86.6		
Johns	2.8	69.0	8.3	45.5
Kahn (standard)	0.2	80.5	0	92.5
Kline	0.2	76.3	1.0	89.4
Kolmer <sup>2</sup>	0.6	75.9	0	77.8
Kurtz <sup>3</sup>	3.0	86.6	0	88.0
Luffkin & Rytz	4.3	84.7	0.9	57.3
Rein <sup>4</sup>	0.9	85.4	0	79.1
Ruediger <sup>2</sup>	2.2	88.2	4.8	96.8
Weiss	0.4	69.4	5.5	74.3
Williams (Army) <sup>2</sup>	0.4	65.8	3.6	86.4

\*The figures in this table are taken from—Cumming, H. S., H. H. Hazen, A. H. Sanford, F. E. Senear, W. M. Simpson, and R. A. Vonderlehr: The Evaluation of Serodiagnostic Tests for Syphilis in the United States, J. A. M. A. 106: 2083-2087 (June 8), 1935.

- <sup>1</sup>Did not perform spinal fluid tests.
- <sup>2</sup>Performed modification of complement fixation tests; all other serologists performed flocculation tests.
- <sup>3</sup>Performed Kahn presumptive test.
- <sup>4</sup>Performed Kline exclusion test.

Chart 2 (taken from "Practical Bacteriology, Haematology, Parasitology," by Stitt, Clough and Clough, through courtesy of The Blakes-ton Co., publishers), shows the results of the Serologic Conference conducted under the auspices of the U. S. Public Health Service and the American Society of Clinical Pathologists in 1934-1935. This sign  $\begin{smallmatrix} + \\ + \end{smallmatrix}$  signifies a complement fixation test; Kurtz performed the Kahn presumptive test and Rein performed the Kline exclusion test. All other serologists performed a flocculation test. For this evaluation each specimen of blood and spinal fluid was divided into thirteen portions and mailed to the respective laboratories in each of which it was to be examined by one method only. The blood was obtained from 152 presumably nor-

mal persons and 415 syphilitic patients, treated and untreated. Blood was obtained also from the following presumably non-syphilitic patients: 62 cases of cancer; 51 cases of jaundice; 53 cases of tuberculosis, and 46 cases of fever. From the table one can see that the Kahn standard test stands out because of its low incidence of false positives on blood sera of 0.2 per cent and its high sensitivity of 80.5 per cent. On the spinal fluids it had no false positives and a sensitivity of 92.5 per cent.

Our central laboratories entered the most recent serologic evaluation test conducted by the U. S. Public Health, the results of which, to my knowledge, have not been published as yet. However, I quote from a letter addressed to Dr. W. A. McPhaul, State Health Officer, from Dr. J. F. Mahoney, Senior Surgeon, United States Public Health Service and Director of the Venereal Disease Research Laboratory: "The results of the performance of the Kahn standard test in the Florida State Laboratories was well above the average of other participants reporting this procedure. You have no doubt noted the high degree of agreement between your reports and those from Dr. Kahn's laboratory. This is probably indicative of adherence to the procedure prescribed by Dr. Kahn himself and should encourage the laboratory force in their efforts to perform a standard technique in a standard manner." In this evaluation test our laboratory had a sensitivity of 76 per cent and a specificity of 100 per cent.

The following form taken from the back of our new Serological Report, gives our interpretation of the meaning of the results of the Kahn test, showing both the old and new terminology. Under the positive might be added the statement that if the following diseases can be ruled out: trypanosomiasis, relapsing fever, infectious mononucleosis, malaria, leprosy and yaws, a persistently positive reaction may be taken as a prima facie evidence of syphilis even in the absence of history and clinical evidence of the disease.

INTERPRETATION

New terminology	Old terminology
Positive:	++++ or +++

A diagnosis of syphilis should not be made on a single positive serological reaction alone. If the serological result is not supported by the history, signs and symptoms, an additional specimen should be submitted as a check examination. If the repeat test confirms the original, syphilis is indicated with a high degree of probability.

Doubtful:

++

Neither makes nor rules out alone the diagnosis of syphilis. If in conjunction with a known history of syphilis and particularly if the patient has been under treatment it may be considered as positive evidence of syphilis. If there is no history or clinical evidence of syphilis, one or more specimens of blood should be submitted for check examination. A provocative injection of neo-arsphenamine may be tried and samples of blood taken on the 2nd and 7th days sent to the laboratory for examination.

Negative:

+ or —

A negative serological report does not exclude syphilis. Frequently positive reactions are not found in the primary stage and after treatment has been instituted. If there is any reason to suspect syphilis, another sample of blood should be submitted for examination.

If time and facilities permitted, the optimum procedure would be to carry out both a flocculation and a complement fixation reaction on every specimen. The next best procedure would be to do another flocculation test in addition to the Kahn standard test and this may be done in the future. However, until that time arrives the Kahn test alone is best suited to our needs, because of simplicity of technical detail, its high sensitivity and high specificity.

#### DISCUSSION

*Dr. Wiley M. Sams, Miami:*

I would like to ask Dr. Patterson if the State Laboratories located elsewhere than in Jacksonville are prepared to do the Kahn presumptive test on serological specimens submitted?

From time to time, I have heard some criticism of the tests as reported by the State Laboratory, on the ground that they were not sensitive enough. On such occasions I have pointed out to a number of physicians that it was much more important to have a test on the insensitive side which will yield few false positives than to have one which is too sensitive, and consequently open to this defect. Many of us, particularly in routine work, are inclined to lean rather heavily on the report of the serological test, and it is important that false positive results be kept at a minimum. I feel that it is much better for a man to have missed the diagnosis because the test is not sensitive enough, than to have made one in a case where it is not warranted.

*Dr. James N. Patterson (Concluding):*

We have transferred the performance of the Kahn test from the Tallahassee and Pensacola laboratories to the central laboratory in Jacksonville. We felt that neither of the branch laboratories had sufficient personnel nor performed enough tests to do them efficiently. Then, too, the one technician in each of these laboratories was frequently interrupted while performing this test by physicians bringing in specimens for immediate examination as for diphtheria, malaria, gonorrhea, etc. These interruptions frequently permitted the saline-antigen mixture to stand too long and allowed irregular periods of incubation, all of which interfered with accurate and uniform results. We feel that where technicians are uninterrupted in their work, as in the central laboratory, that the results are more accurate.

We are continuing to do the Kahn tests at the branch laboratories in Tampa and Miami. We do the Kahn presumptive and the Kahn standard three tube test on every specimen. However, only one report is given, as it

would be confusing to the physicians to receive two reports on the same specimen. We perform the Kahn presumptive and the Kahn standard three tube test on every specimen, not using the presumptive test as a screen test as is done in many laboratories. In the near future we hope to discontinue the Kahn presumptive test and do another test, as the Eagle, Hinton or Kline, in addition to the standard Kahn test.

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#### THE VALUE OF THE TUBERCULIN TEST

P. P. McCAIN, M. D.  
Sanatorium, N. C.

The control of tuberculosis depends largely on early diagnosis and on isolation of the active cases. In order to discover cases of tuberculosis early we cannot wait for symptoms, physical signs and the finding of tubercle bacilli in the sputum, for when these are present the cases are almost always in the advanced and communicable stage and the individuals have already infected the other members of their families.

In order to discover cases in the early stage it is necessary to examine the apparently well, those most likely to have the disease and also those whose occupations are such as to make them a special menace to others, the known contacts, high school and college students, teen age and young adult groups, teachers in all grades and in colleges, industrial workers, nurse maids, food handlers and those living in heavily infected communities.

The examination of these groups should be by means of the tuberculin test to eliminate those who have no tuberculous infections and by making roentgenograms of all positive reactors. As the incidence and mortality rates from tuberculosis decrease there will be a smaller and smaller percentage of persons giving positive tuberculin reactions, fewer roentgenograms will need to be made, and the cost of surveys will be correspondingly less.

By examining those who are apparently well practically all the cases discovered are in the early and curable stage. During the last two years Doctor Logie, of the Division of Tuberculosis of the Florida State Board of Health, tested 12,866 high school students and discovered 72 cases of re-infection type tuber-

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Superintendent, North Carolina Tuberculosis Sanatorium, Sanatorium, N. C.

Read before the Annual Conference on Tuberculosis, Florida Tuberculosis and Health Association, Sarasota, April 3, 4 and 5, 1939.



culosis, of which 77.8 per cent were minimal, 15.3 per cent were moderately advanced and only 6.9 per cent were far advanced. In a survey of 9,000 college students the Extension Department of the North Carolina Sanatorium found 56 cases of re-infection type tuberculosis, of which 80 per cent were minimal and 20 per cent moderately advanced. Such results contrast strikingly with the classification of patients admitted to sanatoria the country over as shown by a recent study by the American Medical Association. Only 13 per cent of the admissions were in the minimal stage, 29.7 per cent in the moderately advanced stage and 57.3 per cent in the far advanced.

Of the various forms of the test, the intracutaneous is by far the most accurate. It is preferable to use a weaker dilution first and, if the test is negative, a stronger dilution in forty-eight to seventy-two hours. When there are large groups to be tested and when there are more applications for clinics than the workers can supply, the writer feels that a practical procedure is to use a single medium sized dose, 0.1 mg. of old tuberculin, or 0.0005 mg. of purified protein derivative. Quite a number of workers use this medium sized dose for group testing. The two-dose procedure will likely show from 8 to 10 per cent more positive reactors, but it is not likely that any clinical cases of tuberculosis will be negative to the medium sized dose.

There are several forms of tuberculin available. Purified protein derivative is unquestionably the best and most specific. Old tuberculin, when prepared and carefully standardized by the best laboratories, is sufficiently accurate to justify its use in the testing of large groups where available funds are limited. It is needful for all preparations of tuberculin to be kept in a refrigerator and for only fresh dilutions to be used.

Almost 100 per cent of those who live in close contact with an open case of tuberculosis will show positive tuberculin reactions. In spite of this fact it is usually wise to give the test to such contacts, for most of them look and feel well and a strongly positive tuberculin test will make such an impression that they will be much more likely to try to keep from getting further infection and will

be more willing to have an annual roentgenologic examination.

The tuberculin test should be employed frequently by all physicians. Tuberculosis control cannot be accomplished without the cooperation and assistance of the rank and file of the medical profession. When a physician discovers a patient with tuberculosis, he should not be content with seeing that the patient gets the proper care and takes the necessary precautions to prevent spreading his infection, but he should give the tuberculin test to all contacts and see that all positive reactors have roentgenologic examinations. The physician should, of course, make a reasonable charge for the administration of the test to those who can pay, and he can doubtless arrange for the county or city health department to give the test to those who are indigent. Provision should be made by the State Board of Health or by the State Tuberculosis Association for physicians to secure tuberculin without charge.

Within recent years articles have appeared in the literature which are causing some doubt and confusion in the minds of some tuberculosis workers as to the value of the tuberculin test. Several authors have reported that many individuals with negative tuberculin reactions show densities in their roentgenograms which are generally considered as typical of calcified tuberculous lesions. In the January 1939 issue of the *U. S. Public Health Journal*, Lumsden, Dearing and Brown, in a study of certain groups, report a lack of correlation between the tuberculin tests and the roentgenologic findings and also in the results of the tests made on the same individuals with different preparations of tuberculin. McKneely, of the Public Health Service, last year at the meeting of the National Tuberculosis Association reported finding many individuals showing calcified lesions and some with lesions supposed to be clinically significant who had negative tuberculin tests in the study of a group at Hagerstown, Maryland.

Most authorities are now of the opinion that a positive tuberculin test indicates existing tuberculous infection, the presence somewhere in the body of live tubercle bacilli. Several years ago Krause reported cases of proved clinical tuberculosis in which, as the disease improved, the tuberculin test became



less pronounced and when the lesions became calcified the tuberculin test became entirely negative. From a practical standpoint, therefore, the test is all the more valuable, since it is negative in individuals with obsolete lesions, and since a positive reaction would indicate the possibility of a clinically significant lesion and the need of further study. As public health workers we are interested not in those who have been infected in the past and whose lesions are now healed, but in those who are now infected and diseased.

The percentage of patients showing calcified lung lesions on roentgenologic examination in some sections of our country is so high that some authorities feel that the lesions may be due to some agent other than the tubercle bacillus. The Research Committee of the National Tuberculosis Association is planning to make an investigation of this phase of the subject.

The lesions considered of clinical significance seen in roentgenograms of persons showing a negative tuberculin test are almost surely due to some non-tuberculous condition, such as pneumonitis, bronchopneumonia or bronchiectasis. Such lesions oftentimes cast shadows on the roentgenograms which strongly simulate tuberculosis. If such densities disappear in a few days or weeks, the lesions are unquestionably non-tuberculous. In any event roentgenologic densities indicating clinically significant lesions in persons with negative tuberculin tests would need to be proved to be tuberculous by other procedures before they could be considered as such. It is often necessary to make a series of films and also necessary to repeat the tuberculin test. In questionable cases it is not only needful to examine the sputum, but also the stomach contents and to use cultures and animal inoculation to establish the diagnosis.

Allergy usually appears within three to seven weeks after infection with tubercle bacilli. McPhedran showed several years ago that occasionally the reaction was delayed and the densities due to inflammatory tuberculous lesions could be seen before allergy appeared. It is generally known, too, that for a few weeks following debilitating diseases, such as influenza or measles, allergy may be suspended and also that in patients desperately sick with tuberculosis their resistance is so low-

ered that they will not react even to large doses of tuberculin. In the latter instance it is, however, usually easy to establish the diagnosis by other means.

In a wide experience extending over twenty-seven years the writer is thoroughly convinced of the reliability of the tuberculin test and of the necessity of its extensive use if tuberculosis is to be brought under control. Probably no biological test is absolutely infallible, but, if the proper safeguards are used, the writer feels that the tuberculin test is as free from error as any other test used in medicine.

Within recent years the veterinarians have almost completely eradicated tuberculosis from the cattle of the United States by the use of the tuberculin test and by slaughtering the positive reactors. We can also control tuberculosis in human beings by finding those infected by means of the tuberculin test, by x-raying the positive reactors and by isolating and treating those with active disease.

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## DIFFERENTIAL DIAGNOSIS IN TUBERCULOSIS WORK

NORVAL M. MARR, M. D.  
St. Petersburg

In preparation of a paper on the differential diagnosis in tuberculosis work, I believe that it is in order to discuss first a few of the rather pertinent points in diagnosis. The points which are to be brought out are quite elementary, but it is felt that they are, nevertheless, important. We will consider tuberculosis as it involves the pulmonary apparatus. An effort will be made to present a few of the common maladies which are most apt to confuse the physician in the diagnosis of pulmonary tuberculosis. We are all conscious of the fact that there are a great many conditions, some common and some rare, which may simulate and imitate the tuberculous state.

The classical primary infection in the lungs has been so well established that exceptions simply tend to prove the rule. For the most part it can be said that primary lesions are practically always the same, irrespective of the patient's age or race. During the past generation there has been a great change in the tuberculosis incidence over the entire world.

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Read before the Annual Conference on Tuberculosis, Florida Tuberculosis and Health Association, Sarasota, April 3, 4 and 5, 1939.

The infection rate has decreased in certain areas to less than half the population, whereas a generation ago over three-fourths were infected before the age of fifteen. For the most part, the adult primary infections are more localized in the parenchyma of the lung, and simulate the reinfection type so closely that they are almost indistinguishable. The common type of parenchymal lesion causes the formation of an infiltrative mass. A rather characteristic feature of these lesions is that they appear in the upper halves of the lungs and there is usually very slight lymph node involvement. An area of infiltration or induration can usually be recognized by percussion and auscultation, unless the area is deep-seated. The importance of rales as an early diagnostic sign of pulmonary tuberculosis is much over-estimated. Rales are important in a person with fever and a bacillary sputum. If they do not accompany secretion or expectoration, and the temperature and sedimentation rate are normal, they are probably cicatricial in nature. Negative percussion and auscultation findings do not exclude a pulmonary process when the lesion is near the hilus, or a miliary state is present.

A history of cough, loss of weight, fatigue, hemoptysis, pleurisy, fever, or night sweats, should make us think of tuberculosis infection. Cough, expectoration, hemoptysis, and weakness usually mean that the disease is advanced, and it behooves us to diagnose tuberculosis before these symptoms have appeared. However, severity of symptoms is not necessarily a measure of the rapidity of the spread of the lesions. All of us can recall the patient who upon examination is found to be in the advanced state of tuberculosis; who had, or at least complained of, very few symptoms; and who was more or less inclined to belittle those symptoms which he had. This is the dangerous type since it can very easily and quickly advance to an open case of tuberculosis. It might be well to mention that the so-called acute upper respiratory infection presents many of the above named symptoms and should always lead us to investigate the possibility of tuberculosis.

One of the most valuable aids in the diagnosis of tuberculosis is the tuberculin test, and this is particularly true in children. When tuberculin comes in contact with cells which

have been rendered sensitive by previous tuberculosis infection, they call forth a definite and prolonged inflammatory reaction. This is the basis for the specific action of tuberculin as a diagnostic aid. It is assumed that when a patient reacts to tuberculin he either has, or has had, tuberculosis infection. On the other hand, failure to react to the tuberculin test does not mean that he does not suffer from tuberculosis, because there are certain conditions under which sensitization may disappear temporarily, as in the case of the exanthemas, influenzal infection, malnutrition, a rapidly spreading tuberculosis with a marked lowering, or even a total disappearance, of the power to react, and in states of extremely low vitality.

The place of the x-ray in the diagnosis of tuberculosis is too well known and recognized to require comment at this time. The place of the sedimentation rate of red corpuscles and its diagnostic value is worthy of mention. It is well recognized that there is an acceleration of the sedimentation time under many and varied conditions, and there is a great deal we do not know about these low rates. However, the fact remains that it is unlikely that a person suffering from active tuberculosis with symptoms of toxemia, will show a normal sedimentation. Therefore, for practical purposes, in the absence of x-ray facilities, the sedimentation test because of its simplicity is a very valuable laboratory aid.

We are all conscious of the many pulmonary conditions which may simulate pulmonary tuberculosis, but time will not permit us to present many of these, and I have selected a few of what I believe to be the more common conditions with which we are confronted in private practice.

The first condition I have in mind is the pulmonary infection secondary to accessory sinus infection, which I believe is more common than diagnosed. In these conditions there is usually a history of repeated sinus infection and a rather persistent cough, which may lead to chronic lesions such as asthma or bronchiectasis. Acute respiratory infections, foreign bodies, pneumonia, measles, and whooping cough frequently precede bronchiectasis. There is a damage to the bronchial wall with loss of elasticity. The chronic local symptom is a productive cough, and it may be men-



tioned here that the sputum of bronchiectasis is not always foul-smelling as was formerly thought. The common physical sign is medium crackling rales persisting in one or both lower lobes and which may lead to the suspicion of tuberculosis. However, to repeat what I said earlier in the paper, rales are not of any great value in establishing the diagnosis of tuberculosis. If bronchiectasis occurs in the lower lobes, which it usually does, there should be no confusion, as tuberculosis invariably starts at the apex and extends downward. However, if the bronchi of the upper lobes are involved it is very difficult to distinguish the two conditions since a tuberculosis excavation and the dilated bronchi may give the same physical signs. The history, x-ray findings essentially negative except for a thickening of the bronchial trunks, absence of tubercles in the sputum, and usually a normal sedimentation rate, should lead to the correct diagnosis. X-ray examination following the trachibronchial installation of a radiopaque oil is also extremely valuable in establishing the diagnosis.

Pneumoniosis is a condition which we may assume is rare in Floridians, but, since we see patients from various sections of the country, it is well to keep this condition in mind. It is due to the inhalation of inorganic dusts, the principal one being silica, and is primarily an occupational disease. It occurs in those individuals who have been exposed to dust containing silica over a number of years. The signs are those of chronic bronchitis with emphysema followed later by fibrosis, and sometimes with right-sided myocardial failure or pulmonary hypertension. The sputum is usually mucopurulent and quite profuse. In the later stages of the disease, tuberculosis may be superimposed. X-ray study and sputum examination are most important to determine whether there is an associated tuberculous state.

There are other non-tubercular chronic bronchial and pulmonary diseases which may be mistaken for tuberculosis, namely, mycotic infection, spirochetal bronchitis, chronic bronchitis, abscess, new growths, syphilis, atypical forms of pneumonia, pneumonitis, and diseases of the pleura. Occasionally, the secondary signs of cardiac disease which occur in the lungs may confuse us. This is particularly true when rales, due to circulatory dis-

turbance, appear in the apex. Mitral stenosis may cause the aforementioned pulmonary signs.

Finally, in differentiating the various pulmonary conditions which may simulate tuberculosis, a careful history and physical examination are in order, together with a correlation of all laboratory procedures such as blood studies, sputum examination, tuberculin test, bronchoscopy, and, lastly and most important, the roentgenologic findings.

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## PRIMARY TUBERCULOSIS IN ADULTS

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Primary tuberculosis in adults is a subject of rapidly growing significance.

Early studies in European cities indicated that nearly all individuals were infected with tuberculosis before reaching adult life. Today, with our lessened incidence of tuberculosis and our extensive facilities for isolating patients or making them non-infectious, fewer and fewer individuals are receiving their first infection in childhood, and more and more after they reach maturity.

Exactly what is meant by the term "primary tuberculosis"? To be exact, it is the term which has recently been adopted by the National Tuberculosis Association to replace the term "childhood type tuberculosis."

The former classification of tuberculosis into "childhood" and "adult" types of tuberculosis was confusing because children were sometimes found to have the adult type tuberculosis, and adults were found to have the childhood type. So, instead of the terms "childhood" and "adult" tuberculosis, we now have the terms "primary" and "reinfection" tuberculosis, and we know that both types occur in individuals of all ages.

What is primary tuberculosis and what is the difference between it and reinfection tuberculosis? Primary tuberculosis is defined as "the totality of the morbid processes following the first implantation of tubercle bacilli." First infection of tuberculosis is usually the result of inhalation of tuberculosis germs. The

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primary infection focus is situated usually in the lower parts of the upper lobes, or in the upper parts of the lower lobes, closely beneath the pleura. This primary lesion consists of a small tuberculous pneumonia. It is, in most instances, a single focus, although multiple foci occur. The center of this focus rapidly undergoes caseation. During the early stages of this lesion, bacilli are carried through the lymph channels to the regional bronchopulmonary lymph nodes, causing in them caseating lesions. The direct anatomical result of a primary infection, commonly called "primary complex," consists, then, of (1) a caseous pneumonic focus in the pulmonary tissue (the parenchymal focus) and (2) one or more foci in the tributary lymph nodes (the regional lymph-node focus). The most frequent development of the primary complex is encapsulation by fibrous tissue, calcification and even ossification of the parenchymal and regional lymph node foci.

First, or primary infection of tuberculosis, is usually benign in character, rarely gives rise to symptoms and infrequently produces a pathology which may be discovered either by a physical or x-ray examination. The most reliable and constant indication that there has been an invasion of the body by the tubercle bacilli is the positive reaction to the tuberculin skin test. It is believed that when the first tubercle bacilli enter the human body, certain protein substances are thrown off by the metabolism of these bacilli which serve to sensitize the tissues of the body so that they become allergic to this substance. This process probably occurs within seven or eight weeks after the original invasion by the tubercle bacilli. The reaction of the body tissues to infection of the tubercle bacilli is quite different in the sensitized or allergic patient from that in the patient who has never developed this allergy. A positive reaction to this test gives definite information that there has been, at some time, an invasion and infection by the tubercle bacilli but gives us no information as to the site of the infection, the time of the invasion or the extent of the pathology that may have occurred as the result of the infection. It tells us that the primary infection having taken place, the tissues are sensitized, and further activity of the tubercle bacilli in that person will probably produce a pathology of the reinfection, or, as it was formerly

known, adult type of tuberculosis. In a small proportion of primary infection cases, the x-ray picture will show some evidence of the pathological process, usually in the lungs or adjoining lymph nodes.

The term "reinfection type tuberculosis" usually refers to the common type of chronic, ulcerative and progressive pulmonary tuberculosis. It is due to reinfection with tubercle bacilli. Inasmuch as reinfection type tuberculosis presupposes a primary infection, it is most prevalent in adult life but does occur in children.

It is not always possible, on the basis of clinical and x-ray findings, to differentiate between primary and reinfection tuberculosis. It is important, however, to determine the type of infection because it has much to do with the prognosis and treatment. In primary tuberculosis the initial focus is a single parenchymal lesion usually in the lower or mid-lung field and in the hilar lymph nodes, while in reinfection tuberculosis, the lesion is a parenchymal focus usually in the upper third of the lung with little involvement of the hilar lymph nodes. In the retrogressive stage of primary tuberculosis, we have encapsulation, calcification and ossification, while in the reinfection type we have resorption, fibrosis and occasionally calcification. In the progressive state of primary tuberculosis, we have lymphatic and hematogenous dissemination, spread by contiguity, while in the reinfection type, we have bronchogenic spread, caseation and liquefaction and excavation. The histological characteristic in primary tuberculosis are fibrotic encapsulation of caseous or calcified foci while in the reinfection type we have fibrous organization of non-resorbed infiltration, caseation and excavation. When the processes follow the course commonly seen, there is little difficulty in determining the type of tuberculosis.

Having discussed the difference between primary and reinfection types of tuberculosis, let us consider for a moment the difference between primary infection of tuberculosis in children and adults.

Dr. Henry C. Sweany, in a recent article, pointed out that in primary infection in adults there is a tendency for the initial invasion to be confined to the parenchyma of the lung with a diminishing lymph node involvement as the patient's age increases. Also, in primary infec-

tion in adults, the tendency is for the lesion to localize in the upper parts of the lung similar to the situation in reinfection type tuberculosis. Furthermore, primary tuberculosis lesions in adults seem much more likely to soften and ulcerate than do primary lesions in children. There is less tendency for the lesion to calcify and when it does calcify, it resembles the lesions of reinfection type tuberculosis. Doctor Sweany suggests that this difference may be due to the change in the anatomy of the lymphatic system with advancing age and believes there is a tendency to localize the infection in adult life rather than to allow it to spread throughout the body. The principal variation between the young and old, so far as tuberculosis is concerned, is the difference in the speed of the growth of the body cells. Fibrous tissues form more slowly in the adult and give the parasites an opportunity to outgrow the capsule, thus leading to the overflowing type of tubercle or to the actual rupture of the tubercle. Actual pathological evidences seem to show that the adult primary infections are more apt to assume the proportions of the reinfection type while in primary tuberculosis in children, there is a tendency to lymphatic spread and tuberculous meningitis.

Doctor Sweany, in this discussion, notes the tendency for primary infection in adults to localize in the apices in contrast to the middle or lower lungs involved in the child. He suggests that it is possible that the adult may have a slightly greater resistance to the invasion of these organisms than is present in the child and that the bacilli fail to find permanent lodging in the bases of the lungs and drift into the apices where they become adapted to the tissues and a lesion develops. Therefore, it should be pointed out that in adults there is often greater difficulty in differentiating primary tuberculosis from the reinfection type than there is in children; first because of the location of the initial lesion; second, because of the frequent absence of gross lymph node involvement; and third, because the healed lesion has more of the appearance of the healed reinfection lesion. Also, it should be remembered that there is a greater tendency for primary tuberculosis in the adult to spread from the initial focus and quickly to assume the characteristics of the reinfection type.

## THERAPEUTIC PNEUMOTHORAX ITS TECHNIQUE, INDICATIONS AND VALUE

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Like many of the procedures now practiced in modern medicine, the therapeutic use of pneumothorax is alleged to date back to the time of Hippocrates. However, in the latter half of the nineteenth century the modern idea of pneumothorax was conceived by Carson and then, several decades later, Forlanini made an extensive study of its use and indications. At approximately the same time John B. Murphy introduced the use of artificial therapeutic pneumothorax into this country. The fight for priority between Murphy and Forlanini is of historical interest but of little value to a brief discussion of the technique, indications and complications of therapeutic pneumothorax.

Pneumothorax is not a "magic bullet" such as Erlich searched for and in no sense of the word is it a substitute for rest and sanatorium care. If I can leave nothing more than the knowledge that pneumothorax is not a cure-all for tuberculosis, I will feel that my time has not been wasted. Rest is the main principle in tuberculosis treatment and pneumothorax supplies local rest to the lung just as a splint rests a fractured limb. In addition to rest, however, collapse therapy produces an approximation of cavity walls and allows them to heal.

Artificial pneumothorax is not an easy simple operation and is safe only in the hands of experienced operators in a sanatorium or hospital where the patient can be watched and the serious emergencies and complications coped with instantaneously. In some localities patients are afraid of the treatment because of the deaths that have resulted from either air embolism, pleural shock or spontaneous compression pneumothorax. The technique used at the State Tuberculosis Sanatorium is as follows:

The patient is placed on his side with a hard pillow under his chest to produce a curve in the spine and spread the ribs on the top side. The skin is prepared with merthiolate and a sterile sheet placed over the area so that the small hole is over the site of election. I prefer the midaxillary line in the fifth interspace be-



cause most adhesions are in the upper chest posteriorly; consequently, a low operative site gives a much higher incidence of successful inductions. The chest wall is then infiltrated with novocain; a small nick is made through the skin with a Bard Parker blade and a No. 18 or No. 19 needle inserted between the ribs into the pleural space. If the needle is advanced slowly you can feel the point go through the parietal pleura. At that moment you will obtain a negative oscillation of the manometer. The entire reading should be on the negative side for the small plus-minus readings encountered are intrapulmonary readings and a negative reading with slight oscillations gradually rising toward the zero or positive level are encountered when the needle is in a vein. A small quantity of air is then introduced and a reading taken. If the reading is still negative enough air is introduced to make 50 cc. and another reading taken; if the pressures are still negative, enough air is added to make a total of 150 to 200 cc. for the initial refill. Refills are given every day for 4 days, gradually increasing the amount of air used daily to 300 cc. Then refills are given 3 times a week using not over 400 cc. at refill and the interval is determined by the intrapleural pressures and the status of the collapse as observed under the fluoroscope. Most operators now prefer small frequent refills so that the bellows effect of large infrequent refills can be eliminated.

To state the indications for therapeutic pneumothorax dogmatically is impossible because each case should be individualized and the recommendations tempered with knowledge gained from continued use of the procedure and close association with treated cases. As a starting point we may say that an open cavity, a positive sputum, x-ray evidence of progression, laboratory evidence of activity such as elevated temperature, change in the blood picture, and accelerated sedimentation test are fairly safe indications for the use of artificial pneumothorax. In addition pulmonary hemorrhage is most easily controlled by an adequate pneumothorax. The beginner is often guilty of overtreatment at both extremes of the disease. The ideal type of patient is the one with predominantly unilateral disease; however, the patient with bilateral disease should not be given up as hopeless merely because his lesion is bilateral. One of the safest

rules for this extreme is to refrain from using pneumothorax on any patient who doesn't have at least two of his original five lobes left uninvolved or unless he has a vital capacity of at least 40 per cent. If the disease has progressed to this extreme, pneumothorax cannot be instituted without causing extreme dyspnea and nearly always the patient's progress will be downhill. However, a few of these patients on bed rest will improve sufficiently to be amenable to collapse therapy at some future date. The other extreme is the minimal and moderately advanced group. A good percentage of this group will become inactive on bed rest alone and since a pneumothorax once started must be continued from three to preferably five years, such patients should be given a trial on bed rest, or simpler collapse therapy such as phrenicotomy. However, at any evidence of progress either by physical examination or x-ray, the appearance of a cavity or the development of a positive sputum should influence the physician to consider seriously some appropriate form of collapse therapy. Another important consideration is the age of the patient. People in the younger age groups (teens and early 20's) require more radical use of collapse therapy because of their tendency to progress. A recent study from the Chicago Municipal Tuberculosis Sanatorium showed that in 70 per cent of minimal cases treated conservatively in the younger age group the patients had recurrences and progressed to become far advanced whereas approximately 100 per cent of this age group treated with pneumothorax remained well once their disease had been pronounced arrested.

The contraindications to pneumothorax likewise are difficult to state dogmatically. The first contraindication to pneumothorax is the inability to produce an adequate collapse. Any pneumothorax which is not producing the desired result is a hazard rather than an asset and if it can't be converted into an adequate pneumothorax, it should be discontinued. Hopeless cases and very early cases are not suitable for artificial pneumothorax unless individualization of the patient changes the picture as noted earlier in the paper. Many observers consider small lower lobe lesions contraindications, until these patients have been given a trial at bed rest and phrenicotomy. Severe myocardial damage is a definite



contraindication because of the strain thrown on the right heart as a result of the encroachment on the pulmonary circulation.

The upper age limit for the use of pneumothorax is not definite. Some doctors are treating patients in their sixties so I prefer to study the patient carefully and if a thorough examination of the cardiorespiratory system, including an electrocardiogram, reveals no physical contraindication, I don't let the patient's age act as a contraindication to the use of some form of collapse therapy. Those in the upper age group may not get well. However, they can often be converted into the so-called maximum benefit type who are no longer a menace to their fellowmen. They may then go home and lead a partially restricted life and probably die of some other degenerative disease of senility.

The complications of therapeutic pneumothorax are numerous and change a simple technique into a serious operation requiring the utmost care and careful watching. The most common complication is pleural effusion. Practically 100 per cent of patients will develop a small amount of fluid at one time or another. The important thing to remember is that the development of fluid is not a contraindication to the continuation of the pneumothorax. Extreme care should be exercised so that the sterile or clear effusion does not become secondarily infected. The treatment of pleural effusion is too large a subject to be included here.

Empyemas both putrid and tuberculous are serious complications and require specialized treatments. The best treatment is the careful adherence to rules of asepsis, thereby preventing their occurrence, if possible.

Spontaneous compression pneumothorax is a serious emergency produced by a needle tear of the lung or the tearing off of an adhesion producing a rent in the lung. During inspiration the rent is open but during expiration the rent is closed; as the pressure builds up, dyspnea develops, producing more forceful breathing and higher pressure in the pleural cavity. If the pressure is not relieved by inserting a needle or trocar, death ensues rapidly. The side to be needled is quickly noted by feeling for the apex beat of the heart and needling the side opposite to the one into which you find the heart displaced.

Air embolism considered by many to be identical with pleural shock is another major emergency. It is produced by air entering the pulmonary veins which are under a negative pressure during inspiration. The treatment is to place the patient in the shock position so the emboli won't reach the brain. Its prevention is through careful adherence to the use of manometer readings and never introducing air unless you have a typical pleural oscillation. When I am inducing an initial pneumothorax I require the patient to return to his bed on a stretcher and remain flat on his back for four hours without a pillow.

Adhesions and mediastinal herniation are common complications and should be mentioned but time prevents any detailed discussion.

In conclusion, let me repeat that artificial pneumothorax is not a cure-all for tuberculosis and unless it is combined with adequate rest and careful sanatorium or hospital supervision, it will fail and your patients will lose faith in the value of the treatment. Furthermore, pneumothorax is effective in only 30 per cent of the cases and must be utilized along with other forms of surgical collapse in order to secure optimum results.

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#### *State Tuberculosis Sanatorium.*

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### WILL THE X-RAY REPLACE THE CLINICIAN IN THE DIAGNOSIS OF EARLY TUBERCULOSIS?

CHARLES M. GRAY, M. D.  
Tampa

In the month of December, 1895, Roentgen announced for the first time his discovery of what later became known as the x-ray. Since that time the advancement in technique and in the art of diagnosis through the use of this medium has been so rapid and spectacular that now, just a short forty-three years later, I have been asked to speak on the subject, "Will the X-ray Replace the Clinician in the Diagnosis of Early Tuberculosis?" I do not know to whom I am indebted for such a title; I do know that whoever it is has given me the opportunity to discuss not only the intended

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subject but also the inferred meanings held within those twelve words.

Will the x-ray replace the clinician in the early diagnosis of tuberculosis? To me such a title, while it expresses well the common trend of thought and habit of expression, is vicious in its implications. In the first place such a statement or question could be, and in too many instances has been interpreted as assuming that any x-ray film, per se, is of paramount importance. The mere making of such a statement should at once suggest its fallacy. So far as the film itself is concerned there is no place in the realm of roentgen diagnosis where exact and meticulous technique is of more importance than in the field of early tuberculosis. Time after time we have had films sent to us for interpretation which were of such poor quality that our report could be only to that effect. To attempt to examine and interpret a film of poor technical quality is not only poor judgment but may actually be misleading. What constitutes a film of good quality is a matter of personal opinion, this leading to the corollary that the film should be taken by the roentgenologist, or one especially trained in the interpretation of chest films, so that a film of the exact quality to which he is accustomed be obtained. Any film will not do and it is up to us, whose responsibility it is to carry on these examinations, to demand that high technical standards be set up and maintained.

Having qualified the question given as the title of this paper in regard to the x-ray film itself am I now in a position to answer it? In my opinion I am emphatically not in such a position, as the question still reads, "Will the X-ray Replace the Clinician in the Early Diagnosis of Tuberculosis?" No x-ray, per se, ever made a diagnosis of anything. My point can be made in no uncertain terms by paraphrasing a quotation of Stone to the effect that "an x-ray film has never made a diagnosis, but an x-ray film in the hands of a roentgenologist has led to many." I call your attention to the fact that I say "in the hands of a roentgenologist," including in that term those men especially trained in the interpretation of chest films. I am emphatically of the opinion that the responsibility for the proper interpretation of x-ray films of the chest in the diagnosis of tuberculosis should be and

must be in the hands of properly qualified men trained in the art of roentgen interpretation.

Roentgenology as a specialty—and I do not think that anyone now will question that it is—has gone through a period in its development which is to me similar to that in which surgery found itself in the early eighteenth century. Those were the years when the surgeons and the barbers were classed as one, the years when anyone so desiring could acquire a set of instruments and announce the opening of an office for the practice of that specialty. There were no standards to be maintained, no qualifications to be met. Such a state of affairs held, as you will remember, until 1745, when, by royal proclamation, the surgeons were formally separated from the barbers and it was made an offense to practice the art without being examined and licensed by ten of their number. From this beginning came the rapid advance in scientific surgery.

Roentgenology has been going through a somewhat similar period. Since 1895 the engineering and technical advance, aided by its background of experience and its personnel of highly trained men, has been rapid. On the other hand, because of the fact that Roentgen's discovery marked the birth of an entirely new procedure, whose very basic principles, so far as medicine was concerned, had to be stumbled onto and later worked out and amplified through the mouth-to-mouth interchange of ideas and applications, the training of men in roentgenology has been comparatively slow. Up to the present time it has been perfectly legitimate for anyone to buy and install x-ray equipment and, by that very fact, set themselves up as experts in x-ray diagnosis—and this even in the face of the fact that they had no training or experience to assume that role. But now, in my opinion, that day is past. In a field as highly specialized as roentgenology, in a specialty where the demand for highly accurate and exact diagnosis is being made daily by both the profession and the laity, I consider it improper and really dangerous for a man to attempt to practice roentgenology without having had several years in actual training. I am of the opinion that the "barber stage" of roentgenology is past, taking with it the period of haphazard, slipshod work.



And how important this is to the future of the diagnosis of early tuberculosis! As I have said before, nowhere in the field of x-ray diagnosis is training and experience of more importance than in tuberculosis of the chest. I feel strongly that this responsibility should be shouldered by trained roentgenologists, and that anyone who attempts to do so solely because of the possession of an x-ray diagnostic unit is definitely out of line, is being unfair to the patient, and is leaving himself open to charges of misconduct.

The thought may be running through your mind that I am taking an unduly long time to come to the question at hand, that I am spending too much time on a mole hill in getting to the mountain. The fact remains, however, that I could not discuss the question without first calling to your attention the erroneous use of the word "x-ray," without first putting myself on a firm basis for such a discussion. And now that I have made the point that in the x-ray diagnosis of tuberculosis of the chest we must have films of highest quality, and a trained roentgenologist to interpret them, I am going to take the liberty to change the subject under discussion to read, "Will the Roentgenologist Replace the Clinician in the Diagnosis of Early Tuberculosis?" This at once gives the reason for the course I have taken and admits a question which can be discussed and, I hope, answered.

The roentgenologist will never replace the clinician in the diagnosis of early tuberculosis. It may seem to you that I am being far too dogmatic in making a pointblank statement such as that but if we look at the question from different angles I think that I can present sound reasons for so saying. In the first place, and this is most important, a roentgenologist, if he is worth his salt at all, is a clinician. It is true that his mode of examination is through the use of the x-ray film rather than the stethoscope, but this does not deny him the right to the use of an accurate history or other means of physical diagnosis, all of which should and must be used in giving him the proper background for the interpretation of the film. In trying to separate the clinician from the roentgenologist I feel that a grave injustice is being done the conscientious and careful roentgenologist.

Again, I feel that the question at point as-

sumes far too much importance for a single diagnostic procedure. I question whether the day will ever come when we, as physicians, can in all honesty attempt to make a diagnosis by a single procedure. I admit the importance of the roentgen examination in the diagnosis of tuberculosis, just as I admit the importance of the cardiograph in the diagnosis of cardiac disease, but I do not admit its omnipotence.

And finally, roentgenologists are, after all, human beings and, as human beings, are susceptible to error. For that reason I feel that every case of suspected tuberculosis referred to the roentgenologist for consultation must have complete, thorough, and accurate physical studies made to serve both as a guiding light and as a check. In other words, and this is the sum and substance of my paper, the roentgenologist and the internist, rather than the one replacing the other, must work hand in hand, pooling their findings and information, and arriving at a diagnosis together.

An objection might now be raised that I am evading the true issue or question intended by the author of the title of this paper, an objection calling attention to those cases showing a minimal apical infiltration found on roentgen examination but missed on routine physical examination because of the paucity or lack of physical signs. I am quite certain that such a point would be thrown at me if this were a radiological meeting. However, I readily admit that I have purposely omitted such a discussion at this time and for several reasons. In the first place, I feel that a discussion of detailed x-ray findings and their interpretation would be rather out of place in a meeting such as this. Secondly, I do not feel that a single x-ray examination is as infallible as some of its too enthusiastic supporters would have one believe. In support of this I call attention to those cases, far more numerous than you might suppose, in which repeated examinations must be done before the roentgenologist can arrive at a diagnosis. The tubercle bacillus, as you see, does not always leave its calling card at the first examination. Again, I feel that while the raising of such a question would probably lead to vigorous discussion and debate, it should serve only to bring us back to the point I have already made, namely, that the roentgenologist and the internist must work together.



There is no question that a roentgen examination may at times pick up an early tuberculous infection which has escaped the stethoscope of the clinician, that in extremely early cases, where the internist can only surmise or suspect tuberculosis, the roentgen examination may confirm the diagnosis, but to me this in no way possible can mean that the examination and opinions of the internist must be abandoned. I have only to remember the very faint, early infiltration of a non-specific pneumonitis, of an early anthracosis, or fungus infection, to realize how important and greatly needed are the careful studies of a skilled internist. The diagnosis of early tuberculosis—I repeat so that I may emphasize—is not the place for grandstand work by any one specialty but is rather a game where teamwork of the highest type must be used.

304 *Citizens Bank Building.*

### MECKEL'S DIVERTICULUM

REPORT OF CASE WITH SIMPLE INVERSION  
CAUSING PARTIAL OBSTRUCTION OF ILEUM

L. W. MARTIN, M.D.

Sebring

There is wide recognition of the persistence of the embryonic vitelline duct or yolk stalk to form a pouch at its union with the intestine in from one to three per cent of all individuals. The yolk sac degenerates about the fourth to sixth month when the abdominal wall closes, and the allantois takes over its function. At the same time the vitelline duct involutes to fibrous strands running from the intestine to the umbilicus in the umbilical cord. Instead of progressing normally to obliteration remnants may persist in any degree from simple strands between the intestine and umbilicus to a diverticulum pouching from the intestine, or even to a perfect tube, a fecal fistula between the intestine and umbilicus.

Meckel's diverticulum may be found at any period in life but in clinical cases reported there is predominance in children and young adults; there is also a predominance in the male sex estimated in different reported series from 4 to 1, to 2 to 1. The anatomy of this anomaly is extremely variable, being represented by a

mere cupola, like out-pouching, or may be a projection 12 inches long, but average diverticulum is the size of a finger with its end rounded, split or lobulated and its point of origin is usually opposite the mesentery of the bowel. Its attachment may be near or even within the mesentery, or it may have a mesentery of its own. The most common site of the diverticulum is 12 to 36 inches proximal to the ileocecal junction, but it may be located anywhere along the small intestine, this variation being due to the place of development of the limbs of the umbilical flexure of the mid-gut.

The presence of Meckel's diverticulum may cause a surgical crisis of such diversity and severity that Fitz considered it a greater menace to life than the appendix. McCann grouped the diverse complications under three general headings as follows:

1. Unusual forms, umbilical polyp, enterocysts, calculi, foreign bodies, polyps, and tumors.
2. Inflammatory, catarrhal and gangrenous, typhoid, peptic, tuberculosis ulcers.
3. Intestinal obstruction, band loop volvulus, pedicle, hernia, intussusception, invagination.

However, there are few references in the literature to simple invagination dissociated from attendant complications. McCann reports a case of simple inversion of a Meckel's diverticulum.

About 44 per cent of all surgical complications arising from diverticulum in different form have been found to be intestinal obstruction.

In 1925 Lower reported a summary of invaginated diverticula producing obstruction and intussusception and this numbered only 25 cases. However, Harkins gave a more complete report, December, 1933, in the *Annals of Surgery* when he reported 160 cases in the literature, with a statistical analysis of 114 cases, including two cases of this combination in which the patients underwent operation at the University of Chicago Clinics.

In these cases, histories of previous abdominal crises were very incomplete but a large number gave a history of previous attacks of varying symptoms and intensities, and usually of such remittancy that it was difficult to tell exactly when the present illness began. Furthermore, since most of these patients were operated upon, the duration of the final attack was as much dependent upon the impression

of necessity for operation that the disease aroused in the minds of the surgeons, as it was upon the severity of the disease itself. The surgeon often tended to delay to make a more definite diagnosis, surgery being used as a last resort. This condition, in cases reported, carried a mortality rate of about 50 per cent.

Pain, most often of a colicky nature, was present in 76 per cent under 1 year of age, and in 85 per cent over this age. Vomiting was present in 92 per cent of cases but due to high obstruction meteorism was not encountered to any great extent. Tenderness and rigidity were present in about equal proportions in about 75 per cent of cases.

Simple invagination of Meckel's diverticulum has been so rare and cases have been so incomplete that no definite conclusion can be drawn as to any differential points from the foregoing. In 1932, McCann reported a case of simple invagination in a boy, aged 6, and in this report he gave a brief, but incomplete summary of ten other cases found in the literature to that date. With the case I am about to report, the total to date is 12 cases. Seven of these patients died and five recovered, giving a mortality of 58 per cent.

#### REPORT OF A CASE OF SIMPLE INVAGINATION

S. F., a male, white, high school pupil, aged 17 years and weighing 110 pounds, had a history of never having been a strong child. He had always been a big eater, suffering from childhood with indigestion and constipation. There was no history of a serious illness and the family history was negative. The patient was brought to my office September 23, with a history of having had a moderate blow on the upper abdomen caused by a fall on a printing press the day before. When he awakened on the morning of the 23rd he suffered with cramps of mild severity in upper abdomen. His temperature was 98 F.; pulse, 84; white cells, 8,000; and urine, negative. There was slight tenderness in upper abdomen, more marked just above and to the right of the umbilicus. A diagnosis of possible injury to intestine from the blow was made and the patient was advised to go to bed, take an enema and eat no solid food.

On September 24, the patient was seen at home, when his pains were of more severe nature, but not localized. There was some vomiting; temperature, 100 F.; pulse, 96; white cells, 10,500. A policy of watchful waiting was now adopted, as no positive diagnosis could be made, the condition presenting no typical picture of abdominal pathology. The patient's condition did not seem to warrant an exploratory operation for possible injury from the blow, due to time elapsed since the injury. An ice bag was applied to the abdomen, fluids were limited, and the patient seemed to improve in the next 24 hours. Pains were less, tenderness was not so marked, and he vomited only twice during this time.

At 10 a. m., September 25, temperature was 99 F.; pulse 110. The patient felt much better but did not look generally improved. He was seen again on September 26 and his condition remained unchanged. There was some

vomiting, but very little pain. Tenderness was still present, but apparently the abdomen was less rigid.

About noon on September 27, the patient was seen in answer to an urgent call, and was found in a critical condition. His temperature was 102 F.; pulse, 140; and he vomited all fluids taken by mouth. There was colicky pain over the whole upper abdomen, which was worse in the area just to the right of and above the umbilicus. The upper abdomen was distended; there were tenderness and some rigidity of the area of most intense pain. The white cell count now was 16,500, with 85 per cent polymorphonuclears. Urine showed three plus albumin with granular casts. After consultation, an immediate exploratory laparotomy was advised, based on a diagnosis of possible peritonitis from injury to the intestine.

An upper right rectus incision was made and upon exploration of exposed small intestine there was definite visible change in size of ileum about 24 inches above ileocecal junction with an apparent obstruction within lumen of gut at this area. Proximally the intestines were distended and red, while distally, the gut was collapsed. Upon palpation at this area the gut was found to be filled with a boggy mass with a hard ball-like mass at proximal end of boggy mass. On further examination of proximal gut the hard mass could be pushed distally within the lumen of the gut, and as this was done an opening was noted near the mesenteric border of gut through which the whole mass was pushed out of intestine and recognized as Meckel's diverticulum. The diverticulum was resected near gut edges, inverted, and closed with purse string suture. The patient showed immediate improvement and was apparently out of danger in three day's time.

The pathologist's report of the specimen removed was as follows:

"The tissue from S. F. consists of an elongated pouch 6 cm. long by 23 mm. in diameter. The peritoneal surfaces are smooth and of a dusky reddish color. The distal end shows a small invagination. In the margin of this invagination there is a surgical incision about 2 cm. long which exposes a large, firmly fixed concretion or fecalith about 2 cm. in diameter. Microscopical sections from the wall of this pouch show the structure of the intestine. The mucosa is quite necrotic. The underlying tissue shows congestion, edema and infiltration with plasma cells and also areas of necrosis in the serosa."

Laboratory opinion: "Meckel's diverticulum, diverticulitis with fecalith and invagination."

Conclusion: Meckel's diverticulum is the remains of embryonic structure of great clinical importance as a cause of abdominal affections. The incidence in all individuals has been variously reported as from one to three per cent. There have been 163 cases of invaginated Meckel's diverticulum with intussusception reported in the literature. Only 11 cases of simple, invaginated Meckel's diverticulum with obstruction of ileum are reported in the literature previous to this report.

An inflamed or invaginated Meckel's diverticulum is an unusual but significant cause of intestinal obstruction, perforation, intestinal hemorrhage, and of many baffling abdominal conditions.



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## PRE-CONVENTION MEETING

The Pre-convention Meeting of the Florida Medical Association, according to an announcement of President Leigh F. Robinson, will be held in Jacksonville, Sunday, January 21, 1940 at the George Washington Hotel. Officers, councilors and members of the various standing committees of the Association are urged to attend. All members of the State Association are also invited to be present at any or all of the sessions.

During the forenoon the Association's Committee on Scientific Work will meet to review applications of those desiring to read scientific papers at the annual convention in Tampa. The program for the scientific sessions will be completed at the Pre-convention Meeting and members who wish to read papers should have their applications in the hands of Dr. Walter C. Jones, chairman of the Committee, not later than January 5.

The Association's Executive Committee and the Council will hold meetings of their groups in the forenoon, to pass on some important matters that are pending.

A luncheon is scheduled at noon, to which all members of the Association are cordially invited. Following the luncheon the twelve

councilors will read their annual reports and submit them for publication in the Journal. Chairmen of standing committees who are present will be called upon for preliminary reports of the activities of their committees. These committee reports need not be submitted in writing, as regular, annual reports will be read at the first meeting of the House of Delegates at the Tampa convention.

Local committees of the Hillsborough County Medical Society are well organized and making elaborate plans for the 1940 convention, under the leadership of Dr. J. R. Boling, general chairman. There will undoubtedly be some interesting announcements at the Pre-convention Meeting concerning the plans of the entertaining society.

## THE PLATFORM OF THE AMERICAN MEDICAL ASSOCIATION

The American Medical Association advocates:

1. The establishment of an agency of federal government under which shall be coordinated and administered all medical and health functions of the federal government exclusive of those of the Army and Navy.

2. The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health and the care of the sick on proof of such need.

3. The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.

4. The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.

5. The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.

6. In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.

7. The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the

quality of medical services and to increase their availability.

8. Expansion of public health and medical services consistent with the American system of democracy.

In publishing the platform in its Nov. 25 issue, *The Journal of the American Medical Association* says:

In the various actions of the House of Delegates during the special session held in Chicago in September last year, and again at the meeting in St. Louis, certain constructive proposals were made which had the full approval of the House of Delegates. Now the Board of Trustees of the American Medical Association has formulated these concepts into a constructive platform for the Association.

The Association advocates:

"1. The establishment of an agency of federal government under which shall be coordinated and administered all medical and health functions of the federal government exclusive of those of the Army and Navy.

Today the medical and health functions of the United States are divided among a multiplicity of departments, bureaus and federal agencies. Thus, the United States Public Health Service is in the Federal Security Agency; the Children's Bureau in the Department of Labor; the Food and Drug Administration in the Department of Agriculture; the Veterans' Administration and many other medical functions are separate bureaus of the government. The WPA, CCC and PWA are concerned with a similarity of efforts in the field of preventive medicine. The Federal Works Administration and the Federal Housing Administration also have some medical functions.

Since 1875 the American Medical Association has urged the establishment of a single agency in the federal government under which all such functions could be correlated in the interest of efficiency, the avoidance of duplication and a saving of vast sums of money. Such a federal health agency, with a secretary in the cabinet, or a commission of five or seven members, including competent physicians, would be able to administer the medical and health affairs of the government with far more efficiency than is now done.

"2. The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health and the care of the sick on proof of such need.

The physicians of the United States have given freely of their time and of their funds for the care of the sick. Their contributions to free medical service amount to at least \$1,000,000 a day. The physicians of this country have urged that every person needing medical care be provided with such care. They have urged also the allotment of funds for campaigns against maternal mortality, against venereal disease and for the investigation and control of cancer. The medical profession does not oppose appropriations by Congress of funds for medical purposes. It feels however that, in many instances, states have sought aid and appropriations for such functions without any actual need on the part of the state, in order to secure such federal funds as might be available. It has also been impossible, under present technics, to meet actual needs which might exist in certain states with low per capita incomes, with needs

far beyond those of wealthier states, in which vast sums are spent.

It is proposed here simply that Congress make available such funds as can be made available for health purposes; that these funds be administered by the federal health agency, mentioned in the first plank of this platform, and that the funds be allotted on proof of actual need to the federal health agency, when that need be for the prevention of disease, for the promotion of health or for the care of the sick.

"3. The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.

Obviously if federal funds are made available to the individual states for the purposes mentioned in the second plank of this platform, there might well be a lessened tendency in many communities to devote the community's funds for the purpose and, in effect, to demand that the federal government take over the problem of the care of the sick. Hence it is suggested that communities do their utmost to meet such needs with funds locally available before bringing their need to the federal health agency, and that the federal health agency determine whether or not the community has done its utmost to meet such need before allotting federal funds for the purpose.

"4. The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.

The medical profession is not static. It wishes to extend preventive medical service to all the people within the funds available for such a purpose. Obviously, this will require not only a federal health agency which may make suggestions and initiate plans, but also a mechanism in each community for the actual expansion of preventive medical service and for the proper expenditure of funds developed both locally and federally. In the development of new legislation, such mechanism may be suitably outlined.

"5. The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.

The medical profession does not yield to any other group in this country in its desire to extend medical care to all those unable to provide themselves with medical service. The American Medical Association through its House of Delegates has already recognized the possible existence of a small group of persons able to provide themselves with the necessities of life commonly recognized as standard in their own communities but not capable of meeting a medical emergency. It is recognized, however, that only persons of the same community fully familiar with the circumstances can determine the number of people who come properly under such classification and that only persons in actual contact with such instances are capable of administering suitably and efficiently the medical care that may be required. Hence it is the platform of the American Medical Association that medical care be provided for the indigent and the medically indigent in every community but that local funds be first utilized and that local agencies determine the nature of the need and control the expenditure of such funds as may be developed either in the community or by the federal government.

"6. In the extension of medical services to all the people, the utmost utilization of quali-



fied medical and hospital facilities already established.

In the so-called National Health Program it is asserted that one half the counties of the United States are without suitable hospitals, and vast sums are requested for the building of new hospitals. In contrast, reputable agencies within the medical profession assert that there are only thirteen counties more than 30 miles removed from a suitable hospital and that in eight of those thirteen counties there are five persons per square mile. In the United States today the percentage of hospital beds per thousand of population is higher than that of any other country in the world. This fact is completely ignored by those who would indulge in a program for the building of great numbers of new hospitals.

Moreover, it seems to be taken for granted that hospital building has languished in recent years, whereas considerable numbers of hospitals have been built with federal funds by various state agencies and also by the PWA, the WPA and the Federal Works Administration.

Analyses may indicate that in many instances such hospitals were built without adequate study as to the need which existed or as to the possible efficient functioning once they were erected. Moreover, there is evidence that in recent years many of the hospitals of the United States known as nonprofit voluntary hospitals have had a considerable lack of occupancy, owing no doubt to the financial situation in considerable part. It seems logical to suggest then that such federal funds as may be available be utilized in providing the needy sick with hospitalization in these well established existing institutions before any attempt is made to indulge in a vast building program with new hospitals. In this point of view the American College of Surgeons, the American Hospital Association, the Catholic Hospital Association, the Protestant Hospital Association and practically every other interested voluntary body agree.

Again it has been argued that the demands for medical care in some sections of the country might require the importation of considerable numbers of physicians or the transportation of numbers of physicians from the areas in which they now are to other areas. In this connection it would seem to be obvious that a change in the economic status of the communities concerned would result promptly in the presence of physicians who might be seeking locations. The utilization of existing qualified facilities would be far more economical than any attempt to develop new facilities.

"7. The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.

In the United States today our sickness and death rates are lower than those of any other great country in the world. This fact was recognized by the President of the United States when he sent the National Health Program to the Congress for careful study. The President emphasized that a low death rate may not mean much to a man who happens to be dying at the time of tuberculosis. The medical profession recognizes the importance of doing everything possible to prevent every unnecessary death. At the same time it has not been established by any available evidence that a change in the system of medical practice which would substitute salaried government doctors for the private practitioner or which would make the private practitioner subject to the control of public officials would in any way lower sickness and death rates.

There exists, of course, the fact that some persons are unable to obtain medical service in the circumstances in which they live and that others, surrounded by good facilities, do not have the funds available to secure such

services. Obviously, here again, there is the question of economics as the basis of the difficulty and perhaps lack of organization in distribution of medical service and a failure to utilize new methods for the distribution of costs which might improve the situation.

The medical profession has approved prepayment plans to cover the costs of hospitalization and also prepayment plans on a cash indemnity basis for meeting the costs of medical care. It continues, however, to feel that the development of the private practice of medicine which has taken place in this country has led to higher standards of medical practice and of medical service than are elsewhere available and that the maintenance of the quality of the service is fundamental in any health program.

"8 Expansion of public health and medical services consistent with the American system of democracy.

Careful study of the history of the development of medical care in various nations of the world leads to the inevitable conclusion that the introduction of methods such as compulsory sickness insurance, state medicine and similar technics results in a trend toward communism or totalitarianism and away from democracy as the established form of government. The intensification of dependence of the individual on the state for the provision of the necessities of life tends to make the individual more and more the creature of the state rather than to make the state the servant of the citizen. Great leaders of American thought have repeatedly emphasized the fact that liberty is too great a price to pay for security. George Washington said 'He who seeks security through surrender of liberty loses both.' Benjamin Franklin said 'They that can give up essential liberty to obtain a little temporary safety deserve neither liberty nor safety.'

In these times, when the maintenance of the American democracy seems to be the most important objective for all the people of this country, the people may well consider whether some of the plans and programs that have been offered for changing the nature of medical service are not in effect the first step toward an abandonment of the self reliance, free will and personal responsibility that must be the basis of a democratic system of government."

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#### NATIONAL PHYSICIANS' COMMITTEE FOR EXTENSION OF MEDICAL SERVICE

"On Nov. 18, in Chicago, a formal meeting of an executive board officially launched a new organization, the National Physicians' Committee for the Extension of Medical Service," a report in *The Journal of the American Medical Association* for Dec. 2 says. "At this meeting the following officers were elected: Dr. Edward H. Cary, Dallas, Texas, chairman; Dr. Austin A. Hayden, Chicago, secretary, and Dr. N. S. Davis III, Chicago, treasurer. These officers were given authority to act as a management committee for the new organization.

"A central committee of more than 800 physicians is being formed, in which all the states will be represented. Some of those already listed in the central committee include

Drs. Howard Morrow, San Francisco; Charles W. Mayo, Rochester, Minn.; Herman L. Kretschmer, Chicago, and Charles Gordon Heyd and Haven Emerson, New York.

"The organization is an independent one, not affiliated in any way whatever with the committee sponsored by Mr. Frank Gannett under the management of Dr. Edward A. Rumely or with the so-called Committee of Physicians or with the American Medical Association. The functions will not, it is stated, overlap or infringe on those of existing county, state or national medical organizations. For its finances, this organization depends wholly on voluntary contributions from physicians, dentists, nurses, hospitals, pharmacists and lay groups interested in the maintenance of the private practice of medicine. In literature released by the Management Committee, the reasons for forming this new institution are stated as follows:

'Medicine is confronted with two new sets of conditions. On the one hand, widespread unemployment, low farm income, and the continuation of conditions of general depression have made it difficult for an ever increasing number of people to pay for the best medical service and proper hospitalization out of earnings.

'On the other hand, there is the trend—worldwide in scope—toward governmental paternalism and the false, suicidal doctrine that the "state" can provide a service and a security that the people cannot otherwise obtain. As related to medicine, the implementing of this concept would effect revolutionary changes in both the practice of medicine and the underlying philosophy which has given it the dynamic quality that resulted in worldwide leadership.

'If the ethical and scientific standards are to be maintained, the independence of American medicine preserved and the public interest best served, American physicians must:

- '1. Make possible the providing of medical service to the indigent and those in the low income groups, and insure the most widespread distribution of the most effective methods and equipment in medicine and surgery.

- '2. Assume the responsibility of countering destructive propaganda by familiarizing the public with the facts in connection with the methods and the achievements of American medicine.'

"The objectives are embodied in a motion, unanimously adopted by the directors:

'*Resolved*, That the National Physicians' Committee for the Extension of Medical Service is a nonprofit, nonpolitical organization for maintaining ethical and scientific standards and extending medical service to all the people . . . and for . . . cooperating with lay and medical institutions and groups, interested in the preservation of national health, to make more generally known the achievements and to safeguard the independence of American medicine.'

"A broadgauge nationwide educational program has been planned and the preliminary steps have been taken to put it in operation.

An effort will be made to familiarize the public with the aims, the methods and the effectiveness of American medicine. It is believed that this will result in generally improving health conditions and will tend to offset propaganda that is altering the point of view of the individual and adversely affecting the status of the physician.

"The Executive Board includes Dr. Edward H. Cary, Dallas, Texas; Dr. Austin Hayden, Chicago; Dr. N. S. Davis III, Chicago; Dr. Irvin Abell, Louisville, Ky.; Dr. F. F. Borzell, Philadelphia; Dr. William F. Braasch, Rochester, Minn.; Dr. John A. Hartwell, New York; Dr. Roger I. Lee, Boston; Dr. Alphonse McMahon, St. Louis; Dr. E. H. Skinner, Kansas City, Mo., and Dr. Charles B. Wright, Minneapolis.

"Mr. John M. Pratt has been secured as executive administrator. The offices are at 700 North Michigan Avenue, Chicago."

#### MEDICAL DISTRICT MEETING—E

The third annual meeting of the South Central Medical District was held at Sanford, Thursday afternoon at 2:30, November 9, with headquarters at the Mayfair Hotel. There was a total registration of 82, of which number 60 were Association members (from this district, 48); 5 were visitors; and 17 were ladies.

The meeting was called to order by Dr. W. C. Page, senior councilor, and the address of welcome given by Dr. T. F. McDaniel, president of the Seminole County Medical Society. The first state officer called on was Dr. Leigh F. Robinson, president of the Association, who gave an interesting resume of the Association's work and activities so far this year. Dr. Herman Watson, chairman of the Council, presented a comprehensive report of the Council's activities. Dr. J. Sam Turberville, president-elect, who made the trip from Century to be present and take part in the meeting, spoke briefly. Dr. Gilbert S. Osincup, chairman of the Association's Executive Committee; Dr. Horace A. Day, chairman of the Association's Committee on Legislation and Public Policy; Dr. J. Rocher Chappell, chairman of the Association's Committee on Medical Education and Hospitals; and Dr. T. Z. Cason, chairman of the Asso-



ciation's Committee on Medical Postgraduate Course, made interesting reports on the activities of their committees. Dr. A. B. McCreary, the state health officer, was given the privilege of the floor and reported that the State Board of Health's districts had been abolished. Three past presidents were present and recognized: Dr. John S. McEwan, Dr. W. Henry Spiers and Dr. Edward Jelks.

Doctor Page called for invitations for the next meeting place and Dr. A. M. Sample, on behalf of the St. Lucie-Okeechobee-Indian River-Martin County Medical Society, invited the doctors to meet at Fort Pierce in 1940. The invitation was unanimously accepted.

After a short intermission the scientific session was called to order by Dr. Sample, junior councilor, and the following program presented: "The Efficacy of Anterior Pituitary Growth Principle in a Diabetic," Dr. George R. Crisler, Winter Park; "Kidney Infection as Result of Obstruction" (illustrated), Dr. Clyde F. Bowie, Leesburg; "Inguinal Hernia" (illustrated), Dr. Don C. Robertson, Orlando; and "A Resume of the First Year's Work at the State Sanatorium" (illustrated), Dr. R. D. Thompson, Orlando.

Following an afternoon boat ride to Blue Springs and various other forms of entertainment, the ladies joined the doctors and guests at the Mayfair Hotel for cocktails, preceding the buffet supper. A delightful buffet supper was served at 7:30 and those present enjoyed an interesting program and pleasant evening. A hearty vote of appreciation was given to Dr. Samuel Puleston, Dr. A. W. Knox and Dr. G. S. Selman, who served on the local arrangements committee.

#### REGISTRATION — DISTRICT E

*Officers:* W. C. Page, Cocoa, senior councilor; A. M. Sample, Ft. Pierce, junior councilor; Stewart Thompson, Jacksonville, managing director.

*Century:* J. S. Turberville. *Daytona Beach:* George M. Green, Ludo von Meysenbug. *Ft. Lauderdale:* Leigh F. Robinson. *Jacksonville:* T. Z. Cason, F. V. Chappell, Edward Jelks,

A. B. McCreary. *Lakeland:* Herman Watson. *Leesburg:* Clyde F. Bowie, L. H. Oetjen, Marion B. O'Kelley. *McIntosh:* J. L. Strange.

*Orlando:* Mitchell M. Andrews, H. H. Caffee, J. R. Chappell, C. J. Collins, Horace A. Day, L. Paul Foster, F. D. Gray, John R. Hatfield, R. P. Henderson, Edgar Hitchcock, H. C. Ingram, Eugene L. Jewett, Hewitt Johnston, John A. Kelk, Lawrence H. Kingsbury, A. C. Kirk, Palmer R. Kundert, C. J. Larsen, Duncan McEwan, J. S. McEwan, W. S. Mitchell, T. A. Neal, L. M. Orr, G. S. Osincup, J. A. Pines, W. P. Rice, Don C. Robertson, Joseph G. Seltzer, W. E. Sinclair, W. Henry Spiers, Walter A. Weed.

*Sanford:* Wade H. Garner, A. W. Knox, W. T. Langley, T. F. McDaniel, C. M. Mitchell, Charles L. Park, Samuel Puleston, D. S. Scott, G. S. Selman, H. D. Smith, J. N. Tolar. *Tallahassee:* B. A. Wilkinson. *West Palm Beach:* L. J. Netto. *Winter Park:* George Crisler.

*Visitors — Jacksonville:* Mr. P. Kemp Williams. *Lakeland:* F. K. Hurt, J. M. Kibler. *Sanford:* Kenneth R. Bell.

*Ladies—Century:* Mary Louise McDonald. *Cocoa:* Mrs. W. C. Page. *Leesburg:* Mrs. L. H. Oetjen, Mrs. M. B. O'Kelley. *Maitland:* Mrs. Jane Backer. *Orlando:* Mrs. H. C. Ingram, Mrs. L. C. Ingram, Mrs. W. S. Mitchell, Mrs. T. A. Neal. *Sanford:* Henrietta H. Bell, Mrs. A. W. Knox, Mrs. T. F. McDaniel, Mrs. Charles L. Park, Mrs. Douglas G. Scott, Mrs. J. N. Tolar. *Tallahassee:* Mrs. B. A. Wilkinson. *West Palm Beach:* Mrs. L. J. Netto.

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*The progress of tuberculosis* in the body is determined by many definite and variable episodes and many more indefinite or contributing factors involving both host and parasite. It is a "battle on many fronts" with the weakest points giving way before the "enemy attack." All classifications, from Bard and Piery down to the present, bear witness to the fact that tuberculosis has many end results leading to many diverse classifications. Sweany, H. C., *Amer. Rev. of Tuber.*, 1939, 39.

## BIRTHS, MARRIAGES AND DEATHS

## BIRTHS

Dr. and Mrs. J. Ralph Vallotton of Daytona Beach announce the birth of a son, Joseph Maxwell, in November.

Dr. and Mrs. M. R. Clements of Tallahassee announce the birth of a son, Merritt Ryals, Jr., on October 29, 1939.

Dr. and Mrs. Charles B. Mabry of Jacksonville announce the birth of a son, Charles Burrows, Jr., on November 8, 1939.

Dr. and Mrs. S. Richard Ombres of West Palm Beach announce the birth of a son, Severn Richard, 2nd, November 19, 1939.

## MARRIAGES

Dr. O. O. Feaster and Dr. Annette M. Bieker, both of St. Petersburg, were married November 9 in Dunedin.

## DEATHS

Dr. A. G. H. Holmes of Miami Beach died at the Jackson Memorial Hospital, Miami, on October 30, following a lingering illness.

Dr. Corbett E. Tumlin of Miami died November 5, following a long illness.

Dr. William H. Dodds of St. Cloud died in Orlando on Sunday, November 26.

## U. S. CIVIL SERVICE EXAMINATIONS

The United States Civil Service Commission announces open competitive examinations for the positions of Junior Medical Officer (rotating internship), \$2,000 a year, and Junior Medical Officer (psychiatric resident), \$2,000 a year, St. Elizabeth's Hospital, Department of the Interior, Washington, D. C. Applications must be on file with the United States Civil Service Commission at Washington, not later than January 2, 1940.

Any member in Florida interested should secure from the United States Public Health Service form number 4, giving complete information and instructions.

## STATE NEWS ITEMS

The following Florida doctors attended the meeting of the American College of Surgeons in Philadelphia, October 16-20: J. Ralston Wells, Daytona Beach; Rabun H. Williams, Eustis; Edwin H. Andrews, John E. Maines, Jr., William C. Thomas, George C. Tillman, Gainesville; James A. Smith, Homestead; Frederick Oetjen, George W. Richardson, E. H. Teeter, Frederick J. Waas, E. C. Watt,

Jacksonville; Robert B. Harkness, Lake City; Bascom H. Palmer, Miami; Herman Boughton, W. Duncan Owens, Frank B. Voris, Miami Beach; Ralph E. Russell, Thomas H. Wallis, Ocala; J. R. Chappell, H. A. Day, Frank D. Gray, C. J. Larsen, Orlando; Julius C. Davis, Quincy; Herbert E. White, St. Augustine; Francis H. Langley, St. Petersburg; John R. Boling, Tampa; Lauchlin M. Rozier, V. D. Stone, West Palm Beach.

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Dr. M. A. Nickle of Clearwater spent two weeks at Mayo Clinic and toured several southwestern states, including California and New Mexico in October.

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The following doctors from Florida attended the Academy of Ophthalmology and Otolaryngology in Chicago in October: M. A. Nickle, Clearwater; L. W. Glatzau, Daytona Beach; W. Jerome Knauer, Shaler Richardson and A. K. Wilson, Jacksonville; M. A. Lischkoff, Pensacola.

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Members of the Florida Medical Association who attended the American Academy of Pediatrics in Cincinnati, November 16-18, were: Warren Quillian, Coral Gables; W. W. McKibben and Samuel J. Roberts, Miami; George N. Leonard and N. O. Pearce, Miami Beach.

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Members of the Florida Medical Association who attended the International Medical Assembly in Chicago recently were: William G. Harris, Charles F. Henley, Jacksonville; Earl H. Roberts, Jacksonville Beach; L. L. Lancaster, Lake Wales; Laura M. Hobbs, C. Larimore Perry, Miami; Eugene B. Maxwell, B. G. Pollock, E. J. Thomas, Miami Beach; James R. Jeffrey, Miami Springs; John S. McEwan, Meredith Mallory, Orlando; R. Bradner Mertz, Tampa.

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Dr. R. Marshall Faver of Miami took post-graduate work in ophthalmology at the Chicago Eye, Ear, Nose and Throat College in November.



Florida doctors who attended the annual meeting of the American Academy of Dermatology and Syphilology in Philadelphia in November were: Lauren M. Sompayrac, Jacksonville; Elmo D. French, Rothwell Lefholz, and Wiley M. Sams, Miami; C. A. Andrews, Tampa.

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The November meeting of the Suwannee River Medical Society was held at Peacock Springs, in the form of a barbecue, at which Dr. O. F. Green of Mayo was host. Dr. John F. Busey, Jr., of Lake City presented a paper on "Hypertension." Visiting doctors were present from Lake City, Jacksonville, Live Oak, Gainesville, Branford, Mayo and Madison.

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Doctors from Florida who attended the annual meeting of the Southern Medical Association in Memphis, November 21-24, are as follows: *Brooksville*: S. C. Harvard. *Century*: J. I. Turberville. *Chattahoochee*: Ralph E. Stevens. *Coral Gables*: F. E. Kitchens, Warren Quillian. *Eustis*: M. M. Hannum. *Ft. Lauderdale*: E. M. Hendricks. *Jacksonville*: Alan Brown, A. F. Caraway, F. V. Chappell, S. E. Driskell, F. L. Fort, L. W. Holloway, F. Gordon King, A. B. McCreary. *Marianna*: N. A. Baltzell. *Miami*: Laura M. Hobbs, W. M. Howdon, Walter C. Jones, Lucille J. Marsh, John D. Milton. *Miami Beach*: F. H. Dieterich, Harrison A. Walker. *Panama City*: William C. Roberts. *Pensacola*: C. C. Webb. *Tampa*: J. C. Dickinson, J. L. Estes, S. B. Forbes, Elsie M. Gilbert, D. L. Sprinkle.

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At the Twelfth Annual Meeting of the Florida East Coast Medical Association, held in Ponte Vedra, November 10 and 11, the following officers were elected:

President—I. M. Hay, Melbourne.

1st Vice-President—E. C. Swift, Jacksonville.

2nd Vice-President—A. J. Logie, Jacksonville.

Sec'y-Treas.—J. S. Stewart, Miami.

The 1940 meeting of the Association will be held in Miami.

Dr. Claude B. Wright of St. Petersburg attended a weeks' intensive postgraduate course at Tulane University in New Orleans in October.

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Dr. B. G. Pollock of Miami Beach attended the recent meeting in Chicago of the Central Society for Clinical Research.

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The annual oyster roast meeting of the Riverside Hospital Staff was held on October 24. Seventy-five doctors attended the scientific meeting, which was held at the hospital, and the oyster roast, which was held at Dr. T. Z. Cason's farm on the banks of the St. Johns River.

The scientific program consisted of the following papers: "Some Notes on Treatment of the Thymic Syndrome in Children" by Dr. W. McL. Shaw, with lantern slides, and "Medicosurgical Problems" by Dr. Webster Merritt, with lantern slides. Doctor Merritt's paper was discussed by Dr. Edward Jelks who emphasized, particularly, surgical problems in gastro-intestinal disease.

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Dr. A. T. Cobb of Gainesville has returned from a vacation, several days of which were spent in study of clinical surgery at Cook County Graduate School of Medicine, Chicago. He also visited other clinics.

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### CORBETT EDWARD TUMLIN

Dr. Corbett Edward Tumlin, who was born in Atlanta, Georgia, in 1893, died at the Jackson Memorial Hospital, Miami, November 5, 1939.

Doctor Tumlin worked his way through the Georgia College of Eclectic Medicine and Surgery, from which he graduated in 1918. He came to Florida and practiced in Volusia County before settling in Miami in 1922. His rise was very rapid and he soon built up a large industrial practice. He was one of the County Surgeons for the Florida Power and Light Company and for nearly ten years a member of the State Board of Medical Examiners, working actively toward the eradication of "snowbirds" who tried to practice

in the Miami area. For several years he was a member of the Legislative Committee of the Florida Medical Association. He was hotel physician for several of Miami's large bay-front hotels and surgeon for the Tropical Park Race Track.

Among the organizations of which he was a member were the Woodmen of the World, Civitan Club, Mahi Shrine Temple, Scottish Rite, Biscayne Lodge of F. and A. M., Royal Arcanum, the Elks, and the American, Florida, and Southern Medical Associations and the Dade County Medical Society. He was president of the newly formed Florida Association of Industrial Surgeons.

Doctor Tumlin is survived by his widow, Mable FitzGibbon Tumlin, and three daughters: Mrs. Marjorie Haggard, Julia and Corbett Elizabeth Tumlin.

Because he was so full of life, so active in medical and civic affairs, he will be greatly missed by his colleagues, by his patients, and by the community at large.

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#### ALBERT GARRETT HOLMES

Dr. Albert Garrett Holmes, 75, resident of Miami since 1900 and one of the city's first physicians, died in Jackson Memorial Hospital October 30, following a lingering illness, which caused his retirement from active practice in 1936.

Doctor Holmes received his preparatory medical training at Hope College, Holland, Mich., and received his medical degree at Rush Medical, now part of the University of Chicago.

He began his practice in Michigan. Later he went on medical duty into the western Indian territory, now the State of Oklahoma. In 1893 he went to Tampa, returning several months later to Chicago, where he served for two years as medical officer on the City Board of Health.

Doctor Holmes came to Miami from Chicago as an employe of the Flagler System on the overseas railroad, a position he held for two years. His family followed him in 1910.

During his career in South Florida, Doctor Holmes served as a federal physician among the Seminole Indians. He was for 11 years a member of the Dade County School Board,

a member of the Central Baptist Church and for 24 years was Superintendent of the Sunday School.

He was a member of the Dade County, Florida and American Medical Associations.

Surviving are the widow, Mrs. Crystal Holmes; three daughters, Mrs. Malcolm Anderson, Mrs. Edna Palmer and Miss Crystal Holmes, and a stepson, Nevin LaHuis, all of Miami.

Doctor Holmes, who ministered to the poor as well as the rich, will be missed by a legion of friends who knew and loved him.

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#### JOSEPH LEE KIRBY-SMITH

Dr. Joseph Lee Kirby-Smith, 57, noted throughout Florida and the South as a dermatologist, died at 3 o'clock, November 5, at his residence, 1894 Edgewood Avenue, Jacksonville, following a brief illness. He had attended to his professional duties until nine days previously.

Doctor Kirby-Smith was born in Sewanee, Tenn., in 1882, next to the youngest of 11 children of Gen. and Mrs. Edmund Kirby-Smith. He was educated at the Sewanee Military Academy and later was graduated with highest honors at the University of the South, where he received his medical degree in 1906.

Doctor Kirby-Smith's graduate work in dermatology in New York City from 1906-1910 included services at Bellevue and allied hospitals, New York City Department of Health Hospitals. He served at the New York Skin and Cancer Hospital as a member of the house staff for a year and a half. He also served as an instructor of dermatology at New York University, Bellevue Hospital Clinic and at Dr. Fordyce's clinic.

He moved to Jacksonville in 1911 where he continued active in his chosen profession. He was married to Miss Lillian Lee Anderson of Jacksonville July 20, 1912.

A pioneer in the field of tropical medicine, he served as chief of the Department of Dermatology at St. Vincent's, St. Luke's and Duval County Hospitals over a period of many years. He also was dermatologist at Riverside Hospital. He lectured by invitation to the London Medical Association on the subject of tropical medicine in the Spring of



1926. In 1927, he was awarded the honorary degree of Sc.D. from the University of the South for research work.

He belonged to the following dermatological and medical associations: Diplomat American Board of Dermatology and Syphilology, 1935; organizer of Florida Dermatological Association, member of the Florida Medical Association, Southern Medical Association, Fellow of American Medical Association, American Society of Tropical Medicine, American Society of Parasitology, American Society of Dermatology.

Doctor Kirby-Smith was a member of Phi Delta Theta fraternity, Florida Yacht Club, Sons of the American Revolution, Illinois chapter, and a member of the Church of the Good Shepherd.

He was a veteran of the World War, in which he served as a first lieutenant and an associate surgeon, U. S. Public Health Service.

Doctor Kirby-Smith is survived by his widow, three daughters, Mrs. P. Warner Frazer of Gainesville, Selden Kirby-Smith and Barbara Kirby-Smith, Jacksonville; by five sisters and two brothers.

## COMPONENT COUNTY SOCIETIES

### BREVARD COUNTY MEDICAL SOCIETY

The October meeting of the Brevard County Medical Society was held on the evening of the 11th at the office of Dr. T. C. Kenaston of Cocoa. A plan for the creation of a County Health Unit to be formed in Brevard in conjunction with Indian River County, was approved. A committee consisting of Drs. I. K. Hicks of Melbourne, T. C. Kenaston of Cocoa and G. E. Christie of Titusville was named to confer with county officials to help work out a plan of organization.

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### DUVAL COUNTY MEDICAL SOCIETY

At the meeting of the Duval County Medical Society held November 7, resolutions were passed regarding the recent death of Dr. J. L. Kirby-Smith, as follows:

### IN MEMORIAM

#### JOSEPH LEE KIRBY-SMITH, M. D.

It is with profound sorrow that we record the death, on Sunday, November 5, 1939, of one of the most outstanding and best loved members of the Duval County Medical Society — Doctor Joseph Lee Kirby-Smith.

Born in Sewanee, Tennessee in 1882, a member of one of the South's oldest and most distinguished families, Doctor Kirby-Smith received his M. D. degree from the University of the South in 1906. For four years thereafter he took post-graduate work in New York, specializing in dermatology. During his twenty-eight years of active practice in Jacksonville, he did pioneer research in dermatology and tropical medicine and won international recognition, largely because of original work on Larvae Migrans.

*BE IT RESOLVED* that in the passing of Doctor Kirby-Smith an irreparable loss has been sustained, not only by the members of this Society, but by the profession at large, as well as by the citizens of this community to whom he ministered untiringly. Gifted with a brilliant mind, an unfailing sense of humor, and possessed of lofty ideals which were never compromised, he won the respect, admiration, and love of an ever-increasing circle of friends and colleagues. His utter devotion to his calling, and his constant effort to elevate the standards of medical practice were an unfailing inspiration to his fellow workers.

*BE IT FURTHER RESOLVED* that a copy of these Resolutions be spread upon the minutes of the Duval County Medical Society; that a copy be sent to his family; and that the same be published in the Journal of the Florida Medical Association.

Very respectfully,

F. L. Fort, M. D., Chairman  
Ben Manhoff, M. D.  
B. F. Woolsey, M. D.  
J. W. Hayes, M. D.  
W. W. Kirk, M. D.  
Russell Dean, M. D.  
Gordon H. Ira, M. D.

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### ESCAMBIA COUNTY MEDICAL SOCIETY

Dr. Toulmin Gaines of Mobile, past-president of the Alabama State Medical Association, was guest speaker at the meeting of the Escambia County Medical Society held at Pensacola, November 14. The subject of Doctor Gaines' paper was "Bromoderma".

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### MANATEE AND SARASOTA COUNTY MEDICAL SOCIETIES

Drs. J. E. Harris and Millard White of Sarasota were principal speakers at a joint meeting of the Manatee and Sarasota County Medical Societies held on the evening of October 18 at the Whitfield Estates, Sarasota.

Doctor Harris presented a paper on "Pulmonary Thrombosis" and Doctor White spoke on "Blood Reactions in the Treatment with Sulfanilamide."

## ORANGE COUNTY MEDICAL SOCIETY

The Orange County Medical Society, having a membership of 85 (the largest in its history) has joined the honor roll of 100% paid societies. Officers who served this society during 1939 were: president, Carl D. Hoffmann; vice-president, Claude Anderson; secretary, Fred Mathers; and treasurer, H. C. Ingram.

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PASCO-HERNANDO-CITRUS COUNTY  
MEDICAL SOCIETY

Dr. S. C. Harvard entertained the Medical Society at the Tangerine Hotel, Brooksville, November 9. A full course chicken dinner was enjoyed at the hotel, followed by the scientific meeting in the parlor of the hotel.

The committee on new charter reported that the charter was ready for signatures so that it may be finally granted by the State incorporating the Medical Society.

Treatment of syphilis was discussed by those present, and Dr. W. H. Walters of Lacoochee reported a case of tape worm.

Dr. Walters invited the Society to hold its next meeting with him in Lacoochee.

Those present were: Drs. J. T. Bradshaw, E. W. Brown, G. R. Creekmore, Geo. A. Dame, W. W. Jones, S. C. Harvard, and W. H. Walters.

\* \* \*

## PINELLAS COUNTY MEDICAL SOCIETY

Members of the Pinellas County Medical Society gathered for a dinner meeting on the evening of November 3 at the Veterans' Facility at Bay Pines. Dr. V. P. Sydenstricker of the University of Georgia, scheduled to be guest speaker was unable to be present, but an interesting scientific program was nevertheless presented by the members of the facility. Talks were given by Dr. W. E. Kendall, chief medical officer; Dr. O. N. Nelson, chief of the ear, eye, nose, and throat division; and Dr. B. T. Wright, chief of the medical service. Doctor Nelson presented a color motion picture showing several operations, including the removal of cataracts.

The Pinellas County Medical Society met at the Power and Light Building, St. Petersburg at 8 p. m., November 17. Senior Censor, Dr. Prescott LeBreton, opened the meeting.

The following were elected to membership: Drs. Francis J. Mantell, Bay Pines; Harold Eugene Weller, St. Petersburg; Robert Johnson Needles, St. Petersburg; Miller Ost McNay, St. Petersburg; John Putnam Rowell, St. Petersburg; Everett Manship Harrison, Dunedin; H. Tuttle Stull, St. Petersburg; Edmund Myers, St. Petersburg, and Elmer Bernard Campbell, St. Petersburg.

Dr. John Herring then took the Chair. He announced the election of Dr. Prescott LeBreton by the Board of Censors as its Chairman. He then introduced the State Health Officer, Dr. A. B. McCreary, who spoke on "Efficient Health Administration." The second speaker was Dr. J. Braden Quicksall who gave a lecture and several reels of motion pictures on "Anesthesia."

PINELLAS COUNTY MEDICAL SOCIETY  
REVIEWS ITS HISTORY

A review of the history of the Pinellas County Medical Society was released recently in a 28-page publication. It is dedicated to Drs. L. B. Dickerson, A. P. Albaugh, J. D. Peabody, W. M. Davis and O. O. Feaster. In the Foreword appears a very interesting writeup entitled "Some Reminiscences" by Dr. W. M. Davis, the society's first secretary-treasurer. Doctor Davis states that in 1912 when Pinellas County became a political unit, the territory having been previously a part of Hillsborough County, several of the physicians who had been practicing in St. Petersburg discussed the founding of the Pinellas County Medical Society.

Although Pinellas County had been separated from its parent county in January, 1912, it was not until the fall of 1913 that a meeting was called to perfect a medical organization. Doctor Peabody, Doctor Wilcox and Doctor Davis became active in starting the organization. None of the physicians practicing in St. Petersburg had been members of the Hillsborough County Medical Society, although many, if not most, of the Pinellas County physicians had been members of organized medicine in other communities before coming to Florida. Tampa was so inaccessible that it would hardly have been possible to attend the meetings there. The only communication at that time with Tampa was a boat which op-





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erated twice daily. The population of St. Petersburg at that time was about 9,000 and the same three to one tourist-permanent population existed then as now. Transportation at that time was a difficult matter for, while a few of the doctors had automobiles, the roads were mere sandy trails through the woods. The first member of this new society to attend an annual meeting of the State Medical Association was Dr. W. M. Davis, in the spring of 1914. The meeting was held in Orlando.

This new publication on the history of the Pinellas County Medical Society from 1913 to 1939 is filled with interesting reading.

\* \* \*

#### POLK COUNTY MEDICAL SOCIETY

Dr. Palmer R. Kundert of Orlando and Dr. Waldo Horton of Winter Haven were principal speakers at the meeting of the Polk County Medical Society held on the evening of October 12. Doctor Kundert's topic was "Epithelial Tumors of the Bladder" and Doctor Horton spoke on "1939 Sub-Tropical Dermatology."

The need for a county health unit was emphasized by members of the Polk County Medical Society at a meeting held in Winter Haven on November 8. A committee was appointed to confer with the county commissioners with reference to the establishment of a health unit.

The scientific program consisted of two papers, one by Dr. Henry Fuller of Mulberry on "Some Aspects of Pernicious Anemia" and the other by Dr. W. W. Shafer of Haines City on "Medical Practice in the Horse and Buggy Days." \* \* \*

#### VOLUSIA COUNTY MEDICAL SOCIETY

The first fall meeting of the Volusia County Medical Society was held at Branandale, just north of New Smyrna Beach on the evening of October 10. There was no formal program but those attending held a round table discussion on cases attended this summer.

Dr. L. V. L. Brown, vice president of the Volusia County Medical Society, presided over the regular monthly meeting of that organization held Tuesday evening, November 14, at Stetson Commons, DeLand. A planked steak dinner was served before adjournment to the lounge for the business and scientific session.

## ABSTRACT DEPARTMENT

*Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.*

**Physiological Effects of Radiation. I. A Study of the *in Vitro* Effect of High Fever Temperatures upon Certain Experimental Animal Tumors, JARES, JOHN J., Rochester, N. Y. (now of Lakeland, Fla.), and WARREN, STAFFORD L., Rochester, N. Y., *Am. J. Roentgenol.*, **41**: 685-708 (May), 1939.**

In the first of a series of studies on the effect of heat and roentgen radiation on normal tissues and varied types of tumors the authors give the results of their experimentation on several animal tumors with high fever temperatures *in vitro*. This type of experimentation has been performed before but only with temperatures in excess of those consistent with human life and under only very simple experimental conditions.

Sections of tumor under closely controlled conditions were subjected to various heat levels and for varied periods of time and were then transplanted into healthy animals.

The thermal death time for mouse sarcoma 180 was found to be 15 hours at 41.5 degrees C. and 8 hours at 42 degrees C. and for the rat carcinoma 13 and 7 hours respectively. Using the suspension method for the Jensen sarcoma the thermal death time was 10 hours and 4 hours at the previously mentioned heat levels and for the Brown Pearce rabbit epithelioma 20 hours at 42 degrees C.

Sublethal exposures show cellular damage both histologically and in the increased prolongation of the appearance time.

There is no permanent alteration in growth characteristic if the tumor starts growing.

**Paraduodenal Hernia, SNYDER, J. W., Miami, *Surgery* **5**: 389-397 (Mar.), 1939.**

Snyder reports a case of paraduodenal hernia, an extremely rare condition probably of embryological origin.

The patient, an active tubercular 51 years of age, had for four years complained of severe abdominal colic after meals, relieved to some extent by heat, enemas and the knee-chest position. On April 6, 1938, phrenic exeresis was performed. Seventeen days after this the





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| 5. Alkali solubility test   |                              |

\*"Treatment of  
Acute Anterior  
Urethritis with  
Silver Picrate,"  
Knight and She-  
lanski, AMERICAN  
JOURNAL OF  
SYPHILIS, GON-  
ORRHEA AND VE-  
NEREAL DISEASES,  
Vol. 23, No. 2,  
pages 201-206,  
March, 1939.

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chemical combination with picric acid. Dosage form for use in  
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patient complained of severe abdominal pain unrelieved by enemas. Emesis and gradual abdominal distention ensued. X-ray revealed dilated loops of ileum with fluid levels.

The abdomen, at operation, contained no intestines, only a tense mass resembling an ovarian cyst, beneath the surface of which intestines could be seen. The mass was opened and intestines allowed to extrude through the sac. The intestines were then reduced through the neck of the sac and the anterior margin of the neck was sutured to the posterior abdominal wall. Two days after operation the patient developed a consolidation of the right base, terminating in death.

The author discusses at length the various theories of origin and gives adequate descriptions of the two main types.

Preoperative diagnosis is based on the history of repeated attacks of abdominal colic with soreness and distention; visible peristalsis and a palpable, resonant, gurgling, balloon-like tumor in the lower abdomen and later involving the entire abdomen. X-ray examination is of paramount value, in that the intestines appear clumped as though "contained in a bag."

**Isolated Injury of the Mesentery Without Perforation of the Abdominal Wall, OWENS, W. DUNCAN, Miami Beach, and McCLAMROCH, J. M., Miami, *Surgery*, 6: 74-75 (July), 1939.**

A two year old child was admitted to the hospital in profound shock with a history of having been struck in the abdomen by cement blocks from a collapsing wall. The picture was one of acute intra-abdominal hemorrhage probably from a ruptured spleen.

On opening the abdomen 200 cc. of blood was suctioned out along with numerous large clots. The spleen, liver and other organs were intact. Exploration of the small intestine revealed a laceration in the mesentery through both leaves at the mid-portion. The laceration was 15 cm. long and there were various bleeding points. These were tied and the laceration repaired.

The postoperative course was stormy but caused no real concern and the child is now in good health.

The authors warn against undue delay in operative interference when dealing with these cases.

## WOMAN'S AUXILIARY

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MRS. E. W. VEAL, Northeast "C".....Jacksonville  
MRS. W. W. HARDEN, Southwest "D".....St. Petersburg  
MRS. FRANK D. GRAY, South Central "E".....Orlando  
MRS. H. A. LEAVITT, Southeast "F".....Miami

## DISTRICT MEETINGS

The third annual meeting of the North Central Medical District was held in Ocala, October 26, 1939. After registration the ladies were taken for a delightful trip in the glass bottomed boats at Silver Springs then to the Highlands Hotel where tea was served and a business meeting held.

Mrs. L. C. Ingram was present and gave a very interesting talk on her plans for the work of the auxiliary.

At seven o'clock the ladies joined the doctors at the Marion Hotel for dinner.

\* \* \*

The meeting for the South Central Medical District was held in Sanford, Thursday, November 9, 1939. The program was carried out as scheduled, a most delightful feature being the boat ride to Lemon Bluff.

On the boat delicious refreshments were served and a business meeting was held. As there are few local auxiliaries in this district, Mrs. Ingram's suggestion that they have a district organization was very favorably received and officers for the remainder of the year were elected. Mrs. Julian N. Tolar, Sanford, will act as president and Mrs. W. C. Page, Cocoa, secretary-treasurer.

Later the ladies and guests joined the doctors at the Mayfair Hotel for cocktails and a buffet supper.

This, being the last of the District meetings for 1939, completes the first year for





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the Woman's Auxiliary District meetings. From the splendid attendance, the delightful entertainment provided at each meeting, and the many complimentary remarks heard for new plans, it is very evident that this new venture will become very popular and profitable, especially with ladies who are not associated with local County Auxiliaries.

\* \* \*

#### TO ALL COUNTY LEGISLATIVE CHAIRMEN

I am passing on to you the suggested program from our National chairman, Mrs. Arthur A. Herold, with the hope that each county auxiliary will cooperate in making the legislative department this year one of outstanding interest and education to all members. If we do nothing more than educate ourselves along the lines of legislation, it will be a step forward in our work. Please report to me any activities that you sponsor so that I may include them in my report to Mrs. Herold at the close of the year.

Looking forward to hearing from you and with very best wishes for your success I am,

Faithfully yours,  
Minnie R. Copeland, (Mrs. S. M.)  
Chairman State Legislation.

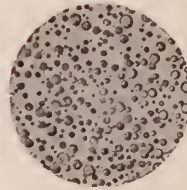
1. Objective:
  1. Self Education.
  2. Intelligent cooperation with your local Medical Society.
  3. Education of the public.
2. Plan:
  1. Self Education.
    - (a) Study groups specifically studying pending Federal legislation, with special stress laid on "The Wagner Health Bill."
    - (b) Every Auxiliary meeting allotting time for "Medical Current Events."
    - (c) Constant reading of your A. M. A. Journal and respective State Medical Journals.
    - (d) Keep file of newspaper clippings and pamphlets pertaining to medical legislation.
  2. Intelligent cooperation with your Medical Society.
    - (a) Alert and wide awake Auxiliary membership.
    - (b) Every Auxiliary member registered.
    - (c) Every Auxiliary member voting.
    - (d) With approval of your State and local Medical Society make contacts with your Congressmen and Senators.
3. Education of the public.
  - (a) Request that doctors furnish "Speakers" of those especially interested in and well informed on "Medical Economics." Suggest that our auxiliary members make engagements for doctors to speak on programs of P.-T. A. groups and all other clubs, especially the men's luncheon clubs.
  - (b) Encourage your members to affiliate with other clubs and to serve as officers on their boards, for then they may ask that authentic information on health be presented at their club meetings. This phase of your work should be worked out in cooperation with your Chairman of Public Relations.

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- (c) Emphasize whenever you hear "Socialized Medicine" discussed, the fact that preventive medicine—not mere spending of money, is of importance. There is no such thing as free medicine—you pay for it in taxes. Make argument specific rather than general, for remember, a person is always more interested in what concerns him personally.

## COUNTY AUXILIARY MEETINGS

### POLK COUNTY AUXILIARY

*Submitted by Mrs. J. R. Boulware*

The Auxiliary to the Polk County Medical Society held a dinner meeting at the Lake Region Hotel in Winter Haven, November 11, 1939. Mrs. C. H. Murphy of Bartow, who presided, urged all members to support the Tuberculosis Christmas seal sale, keeping in mind the benefit to Camp Miller.

Mrs. R. L. Cline read a news letter from the Auxiliary Bulletin and Mrs. R. H. Mooty of Winter Haven read an article on "Hygeia" from the same magazine. Attention was called to the American Medical Association's broadcast over NBC, Thursday afternoons at 4:30, on "Medicine in the News."

Those present were Mrs. C. H. Murphy, Bartow; Mrs. Eugene Meneray, Mrs. S. Allen Clark, Mrs. John Jares, Mrs. R. L. Cline, Lakeland; Mrs. F. E. Irons, Mrs. Ivan Gessler, Mrs. W. T. Simpson, Mrs. R. H. Mooty, Winter Haven; and Mrs. W. W. Shafer, Haines City.

\* \* \*

### DUVAL COUNTY AUXILIARY

The October meeting of the Woman's Auxiliary to the Duval County Medical Society was held in the home of Mrs. S. R. Norris, 1853 Edgewood Ave., with Mrs. Luther W. Holloway and Mrs. E. C. Swift, as co-hostesses.

Mrs. C. E. Royce, president, presided. Mrs. John F. Lovejoy, Public Relations Chairman, announced that a Health Institute would be held again next spring with a number of prominent speakers appearing on the program. An effort will also be made to sponsor programs in some of the outlying districts and at the Woman's Club.

Mrs. J. W. Hayes, Philanthropic Chairman, outlined a number of activities that will be undertaken by her committee. She stated that Mrs. Louie Limbaugh and Mrs. Eugene Simmons had prepared the menu for

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**OTOLARYNGOLOGY**—Two Weeks' Course starting April 8, 1940. Informal Course every week.

**OPHTHALMOLOGY**—Two Weeks' Course starting April 22, 1940. Informal Course every week.

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the doctors at the last meeting of the Duval County Medical Society. The Auxiliary voted to donate \$25.00 for this department during the coming year.

Mrs. S. R. Norris, introduced the guest speaker, Dr. Edward Jelks, who gave an educational address on State Medicine. Doctor Jelks stated that it was the purpose of the medical profession to raise the standard of medical practice and paid high tribute to the present system now in use in the United States. He said that State Medicine is a subject worthy of deepest thought and consideration and illustrated with diagrams and figures the importance of studying this subject well before drawing conclusions as it might seriously affect the great masses.

At the close of the meeting members were invited into the dining room where delicious refreshments were served from an attractively appointed table overlaid with a beautiful white embroidered linen cover and centered with a lovely arrangement of yellow chrysanthemums in a flat crystal bowl surrounded with yellow crystal bubbles. Tall lighted tapers in twin crystal candelabra stood on either side. Mrs. C. E. Royce poured. About forty members and guests were present.

### BOOKS RECEIVED

DO YOU WANT TO BECOME A DOCTOR? By MORRIS FISHBEIN, M.D., Editor *Journal of American Medical Association*. For the young man about to enter college and for the medical student this book surveys the whole field of medicine today, describing in detail the several stages of academic preparation, and offering much practical advice on the opportunities, work and obligations in general medical practice and in certain related professions. It is strictly up to date, taking cognizance of the changing social, legislative and economic factors which are affecting the medical profession more and more. The high-school senior will find here a complete synopsis of the required training for becoming a doctor. He is told how to select a college and the courses of study best suited to his purpose. The essentials of a good medical school are defined; followed by a list of every approved medical school in the U. S. A. and Canada. Comparative costs under varying circumstances are considered. The important postgraduate work of the intern is fully discussed. A final chapter covers medical organizations and their relation to the physician and the public. Cloth. Pp. 176. Price \$1.50. New York: Frederick A. Stokes Co., 1939.



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| \$50.00 weekly indemnity, accident and sickness | \$66.00 per year |

|                                                 |                  |
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## COMPONENT SOCIETIES BY DISTRICTS — FLORIDA MEDICAL ASSOCIATION

| Districts                                                 | COUNTY SOCIETIES                         | PRESIDENT                                                          | SECRETARY                                                           | MEETING DATE                                                             | COUNCILOR and Counties Not Included in First Column | Members |      |
|-----------------------------------------------------------|------------------------------------------|--------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------|---------|------|
|                                                           |                                          |                                                                    |                                                                     |                                                                          |                                                     | Total   | Paid |
| Northwest District (A)<br>Marianas<br>July 20, 1939       | Bay                                      | Donald S. Fraser, M.D.<br>Panama City                              | William C. Roberts, M.D.<br>Panama City                             |                                                                          | A-1-'40<br>Carol C. Webb, M.D.<br>Pensacola         | 12      | 100% |
|                                                           | Escambia                                 | L. C. Fisher, Jr., M.D.<br>816 N. Palafox St.<br>Pensacola         | J. M. Hoffman, M.D.<br>1221 E. DeSoto St.<br>Pensacola              | 2nd Tuesday<br>8:00 P. M.                                                |                                                     | 44      | 40   |
|                                                           | Walton-Okaloosa                          | A. G. Williams, M.D.<br>Lakewood                                   | R. B. Spires, M.D.<br>DeFuniak Springs                              | 3rd Thursday<br>8:00 P. M.                                               |                                                     | 6       | 100% |
|                                                           | Washington-Holmes                        | W. D. Ramsey, M.D.<br>Noma                                         | L. H. Paul, M.D.<br>Bonifay                                         |                                                                          | Santa Rosa                                          | 8       | 7    |
|                                                           | Franklin-Gulf                            | Chapman Dykes, M.D.<br>Carrabelle                                  | A. L. Ward, M.D.<br>Port St. Joe                                    | 3rd Thursday                                                             | A-2-'41<br>B. A. Wilkinson, M.D.<br>Tallahassee     | 6       | 100% |
|                                                           | Jackson                                  | C. J. Price, M.D.<br>Alford                                        | R. N. Joyner, M.D.<br>Marianna                                      | 2nd Tuesday<br>7:30 P. M.                                                |                                                     | 13      | 12   |
|                                                           | Leon-Gadsden-Liberty-Wakulla-Jefferson   | Francis T. Holland, M.D.<br>208 Midyette-Moor Bldg.<br>Tallahassee | B. A. Wilkinson, M.D.<br>Telephone Bldg.<br>Tallahassee             | Quarterly<br>3:00 P. M.                                                  | Calhoun                                             | 33      | 34   |
| North Central District (B)<br>Ocala<br>October 26, 1939   | Columbia                                 | W. M. Ives, M.D.<br>132 N. Marion St.<br>Lake City                 | Harry S. Howell, M.D.<br>Blanche Hotel Annex<br>Lake City           | 1st Monday<br>7:30 P. M.                                                 | B-3-'41<br>W. S. Nichols, M.D.<br>Lake City         | 21      | 16   |
|                                                           | Madison                                  | E. Long, M.D.<br>Madison                                           | A. F. Harrison, M.D.<br>Madison                                     |                                                                          |                                                     | 3       | 2    |
|                                                           | Taylor                                   | Geo. H. Warren, M.D.<br>Perry                                      | Ralph J. Greene, M.D.<br>Perry                                      | Last Friday<br>8:00 P. M.                                                | Baker-Dixie-Hamilton-Lafayette-Suwannee             | 8       | 6    |
|                                                           | Alachua                                  | J. E. Malmes, Jr., M.D.<br>433 E. Main St. N.<br>Gainesville       | J. Maxey Dell, Jr., M.D.<br>333 W. Main St., S.<br>Gainesville      | 2nd Friday<br>7:30 P. M.                                                 | B-4-'40<br>James L. Strange, M.D.<br>McIntosh       | 29      | 27   |
|                                                           | Marion                                   | Carl S. Lytle, M.D.<br>Dunnellon                                   | R. C. Cumming, M.D.<br>Commercial Bank Bldg.<br>Ocala               | 3rd Thursday<br>12:30 P. M.                                              |                                                     | 23      | 100% |
|                                                           | Pasco-Hernando-Citrus                    | Claude L. Carter, M.D.<br>Inverness                                | G. R. Creekmere, M.D.<br>Brooksville                                | 2nd Thursday<br>7:00 P. M.                                               |                                                     | 15      | 100% |
|                                                           | Sumter                                   |                                                                    | A. B. Albrighton, M.D.<br>(Acting Secretary)<br>Wildwood            | 2nd Tuesday                                                              | Bradford-Gilchrist-Levy-Union                       | 3       | 2    |
| N. E. District (C)<br>Palatka<br>September 14, 1939       | Duval                                    | Chas. B. Mabry, M.D.<br>439 St. James Bldg.<br>Jacksonville        | Lauren M. Sompayrac, M.D.<br>459 St. James Bldg.<br>Jacksonville    | 1st Tuesday<br>8:15 P. M.                                                | C-5-'41<br>R. B. McIver, M.D.<br>Jacksonville       | 175     | 173  |
|                                                           | St. Johns                                | R. D. Harris, M.D.<br>St. Augustine                                | G. Walter Potter, M.D.<br>East Coast Hospital<br>St. Augustine      | 3rd Tuesday<br>8:30 P. M.                                                |                                                     | 10      | 100% |
|                                                           | Putnam                                   | Edward W. Ford, M.D.<br>Crescent City                              | C. M. Knight, M.D.<br>Palatka                                       | 2nd Tuesday in<br>Feb., April, June,<br>Aug., Oct., Dec.<br>7:00 P. M.   | C-6-'40<br>George M. Green, M.D.<br>Daytona Beach   | 11      | 100% |
|                                                           | Volusia                                  | Maximilian Stern, M.D.<br>Box 5098<br>Daytona Beach                | R. L. Miller, M.D.<br>258½ S. Beach St.<br>Daytona Beach            | 2nd Tuesday<br>7:30 P. M.                                                | Flagler                                             | 41      | 40   |
| Southwest District (D)<br>Lakeland<br>September 28, 1939  | Hillsborough                             | J. W. Alsobrook, M.D.<br>120 N. Collins St.<br>Plant City          | James S. Grable, M.D.<br>811 Citizens Bank Bldg.<br>Tampa           | 1st Tuesday<br>8:00 P. M.                                                | D-7-'41<br>W. C. McConnell, M.D.<br>St. Petersburg  | 111     | 102  |
|                                                           | Manatee                                  | S. G. Hollingsworth, M.D.<br>451 12th St.<br>Bradenton             | M. M. Harrison, M.D.<br>Professional Bldg.<br>Bradenton             | 3rd Tuesday<br>7:00 P. M.                                                |                                                     | 14      | 100% |
|                                                           | Pinellas                                 | John A. Herring, M.D.<br>259 Third St., No.<br>St. Petersburg      | W. C. McConnell, M.D.<br>1001 First Federal Bldg.<br>St. Petersburg | 1st and 3rd Fridays<br>6:30 P. M.                                        |                                                     | 95      | 100% |
|                                                           | Sarasota                                 | T. W. Taylor, M.D.<br>Professional Bldg.<br>Sarasota               | Stanley T. Martin, M.D.<br>Sarasota                                 | 2nd Tuesday<br>8:30 P. M.                                                |                                                     | 17      | 14   |
|                                                           | DeSoto-Hardee-Highlands-Charlotte-Glades | Ben D. Spears, M.D.<br>Wauchula                                    | Howard V. Weems, M.D.<br>22 Oak St.<br>Sebring                      | 2nd Tuesday<br>8:00 P. M.                                                | D-8-40<br>Herman Watson, M.D.<br>Lakeland           | 20      | 100% |
|                                                           | Lee                                      | C. Gordon Merrick, M.D.<br>26 Leon Bldg.<br>Fort Myers             | H. L. Allan, M.D.<br>312 Pythian Bldg.<br>Fort Myers                | 3rd Friday<br>7:30 P. M.                                                 |                                                     | 14      | 13   |
|                                                           | Polk                                     | John F. Wilson, Jr., M.D.<br>Box 254<br>Lakeland                   | J. R. Boulware, Jr., M.D.<br>P. O. Box 367<br>Lakeland              | 2nd Wednesday in<br>Feb., April, June,<br>Aug., Oct., Dec.<br>1:00 P. M. | Collier-Hendry                                      | 62      | 100% |
| South Central District (E)<br>Sanford<br>November 9, 1939 | Brevard                                  | W. J. Creel, M.D.<br>Eau Gallie                                    | I. K. Hicks, M.D.<br>Melbourne                                      | 3rd Tuesday                                                              | E-9-'40<br>W. C. Page, M.D.<br>Cocoa                | 11      | 9    |
|                                                           | Lake                                     | W. G. DeVane, M.D.<br>Groveland                                    | Oliver Emerson, M.D.<br>Tavares                                     | 1st Thursday<br>12:30 P. M.                                              |                                                     | 18      | 16   |
|                                                           | Orange                                   | C. D. Hoffmann, M.D.<br>120 E. Robinson St.<br>Orlando             | Fred Mathers, M.D.<br>Box 53<br>Orlando                             | 3rd Wednesday<br>8:30 P. M.                                              |                                                     | 85      | 100% |
|                                                           | Seminole                                 | Thomas F. McDaniel, M.D.<br>Seminole County Bank Bldg.<br>Sanford  | Douglas G. Scott, M.D.<br>212 N. Park Ave.<br>Sanford               | 2nd Monday<br>7:00 P. M.                                                 | Osceola                                             | 12      | 100% |
|                                                           | St. Lucie-Okeechobee-Indian River-Martin | J. D. Parker, M.D.<br>Box 942<br>Stuart                            | Adrian M. Sample, M.D.<br>Ft. Pierce                                | 3rd Thursday<br>8:00 P. M.                                               | E-10-'41<br>A. M. Sample, M.D.<br>Ft. Pierce        | 18      | 100% |
| S. E. District (F)<br>West Palm Beach<br>October 12, 1939 | Broward                                  | R. L. Elliston, M.D.<br>814 Sweet Bldg.<br>Ft. Lauderdale          | Oliver C. Brown, M.D.<br>915 Sweet Bldg.<br>Ft. Lauderdale          | 4th Wednesday<br>8:00 P. M.                                              | F-11-'40<br>Lloyd J. Netto, M.D.<br>West Palm Beach | 34      | 100% |
|                                                           | Palm Beach                               | Gaylord Lewis, M.D.<br>916 Harvey Bldg.<br>W. Palm Beach           | C. Jennings Derrick, M.D.<br>Box 574<br>W. Palm Beach               | 4th Monday<br>8:00 P. M.                                                 |                                                     | 62      | 100% |
|                                                           | Dade                                     | M. Jay Flipse, M.D.<br>305 Huntington Bldg.<br>Miami               | Franz Stewart, M.D.<br>1105 Huntington Bldg.<br>Miami               | 1st Tuesday<br>8:30 P. M.                                                | F-12-'41<br>Kenneth Phillips, M.D.<br>Miami         | 297     | 288  |
|                                                           | Monroe                                   | Harry C. Galey, M.D.<br>532 Fleming St.<br>Key West                | W. R. Warren, M.D.<br>511 Eaton St.<br>Key West                     | 1st Sunday<br>9:00 P. M.                                                 |                                                     | 4       | 100% |



STATE AND SECTIONAL MEETINGS

| SOCIETY                           | PRESIDENT                         | SECRETARY                           | ANNUAL MEETING                   |
|-----------------------------------|-----------------------------------|-------------------------------------|----------------------------------|
| Florida Medical Association.....  | Leigh F. Robinson, Ft. Lauderdale | Shaler Richardson, Jacksonville     | Tampa, Apr. 29, 30 & May 1, 1940 |
| Florida Medical Districts:        |                                   |                                     |                                  |
| A—Northwest .....                 | B. A. Wilkinson, Tallahassee      | Stewart Thompson, Jacksonville      | Pensacola, 1940                  |
| B—North Central .....             | William S. Nichols, Lake City     | " " "                               | Lake City, 1940                  |
| C—Northeast .....                 | Robt. B. McIver, Jacksonville     | " " "                               | Daytona Beach, 1940              |
| D—Southwest .....                 | W. C. McConnell, St. Petersburg   | " " "                               | Dunedin, 1940                    |
| E—South Central .....             | A. M. Sample, Ft. Pierce          | " " "                               | Ft. Pierce, 1940                 |
| F—Southeast .....                 | Kenneth Phillips, Miami           | " " "                               | Key West, 1940                   |
| Alabama Medical Association.....  | M. S. Davie, Dothan               | D. L. Cannon, Montgomery            | Birmingham, April 16-18, 1940    |
| Georgia Medical Assn. of.....     | W. H. Myers, Savannah             | E. D. Shanks, Atlanta               | Savannah, April 23-26, 1940      |
| Florida—                          |                                   |                                     |                                  |
| State Dental Association.....     | E. B. Penn, Miami                 | E. C. Lunsford, Miami               | St. Petersburg, Nov., 1940       |
| Soc. of Derm. and Syph.....       | Alan Brown, Jacksonville          | Lauren M. Sompayrac, Jacksonville   | Tampa, Apr. 29, 1940             |
| East Coast Medical Association    | I. M. Hay, Melbourne              | J. S. Stewart, Miami                | Miami, 1940                      |
| State Hospital Association.....   | J. H. Therrell, Chattahoochee     | Mr. Fred M. Walker, Jacksonville    | Mississippi, March, 1940         |
| Assn. of Industrial Surgeons..... | Harrison A. Walker, Miami Beach   | A. M. Bidwell, Tampa                | Tampa, Apr. 29, 1940             |
| Internists' Society.....          | Norval M. Marr, St. Petersburg    | Kenneth Phillips, Miami             | Tampa, Apr. 29, 1940             |
| Medical Postgraduate Course...    | Turner Z. Cason, Jacksonville     | Chairman                            | Jacksonville, 1940               |
| Soc. of Ophthal. & Otol.....      | S. B. Forbes, Tampa               | Temporary Chairman                  | Tampa, Apr. 29, 1940             |
| State Nurses Association.....     | Mrs. M. Stetson, St. Petersburg   | Mrs. Phyllis Leonard, St. Augustine | Pensacola, Nov. 1940             |
| Pediatric Society .....           | Warren W. Quillian, Coral Gables  | G. N. Leonard, Miami Beach          | Tampa, 1940                      |
| Pharmaceutical Association.....   | Mr. S. F. Harris, Jacksonville    | Mr. A. W. Morrison, Miami           | Tampa, May, 1940                 |
| Public Health Association .....   | A. B. McCreary, Jacksonville      | E. M. L'Engle, Jacksonville         | Tampa, 1940                      |
| Radiological Society .....        | H. B. McEuen, Jacksonville        | J. N. Moore, Ocala                  | Tampa, Apr. 29, 1940             |
| Railway Surgeons' Association...  | H. D. Clark, Ft. Pierce           | W. C. Page, Cocoa                   | Tampa, Apr. 28, 1940             |
| Tuberculosis & Health Assn....    | Mr. G. E. Therry, W. Palm Beach   | Mrs. May Pynchon, Jacksonville      | Spring, 1940                     |
| Chattahoochee Valley Med. Assn.   | M. Y. Dabney, Birmingham          | Frank K. Boland, Atlanta            | Albany, Ga., July 9-11, 1940     |
| Gulf Coast Clinical Society.....  | J. H. Dodson, Mobile              | C. C. Rouse, Mobile                 | Mobile, Oct. 26-27, 1939         |
| Southeastern Derm. Assn.....      | Jack Jones, Atlanta               | Howard Hailey, Atlanta              | Atlanta, Ga., Sept. 1, 1940      |
| Southeastern Surgical Congress... | R. L. Sanders, Memphis            | B. T. Beasley, Atlanta              | Birmingham, Mar. 11-13, 1940     |
| Southern Medical Association..... | Arthur T. McCormack, Louisville   | Mr. C. P. Loranz, Birmingham        | Louisville, Nov. 12-15, 1940     |
| Swansee River Medical Society...  | T. H. Bates, Lake City            | H. S. Howell, Lake City             |                                  |

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# The JOURNAL of the Florida Medical Association, Inc.

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## NEXT SESSIONS

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Florida Medical Association, Tampa, April 29, 30, and May 1, 1940  
Southern Medical Association, Louisville, Ky., November, 1940

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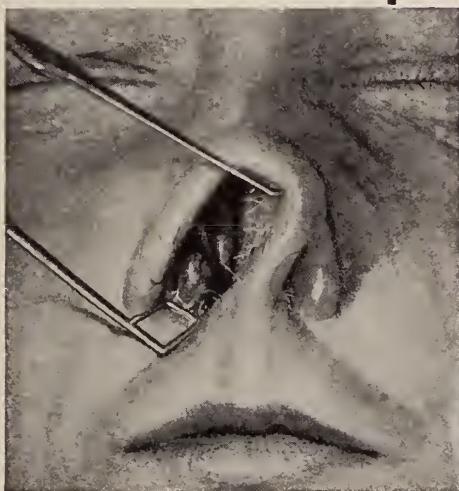


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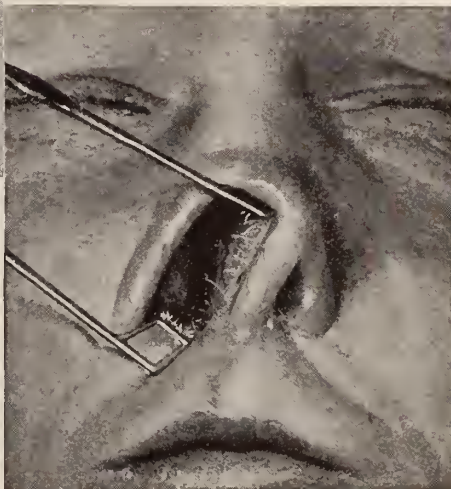


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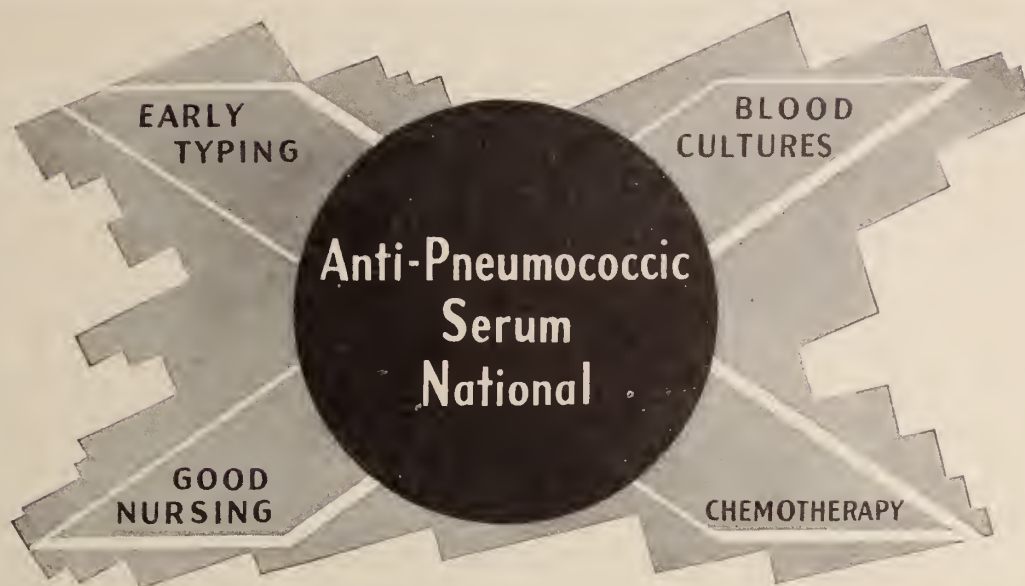
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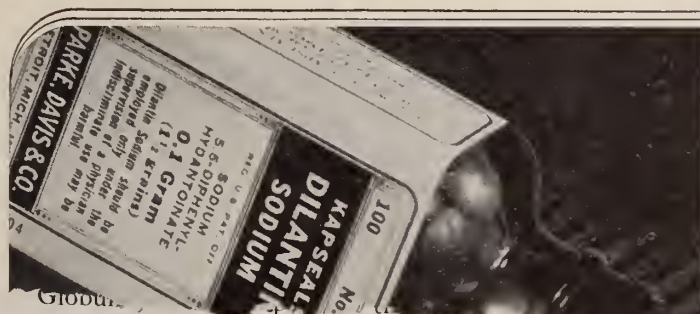
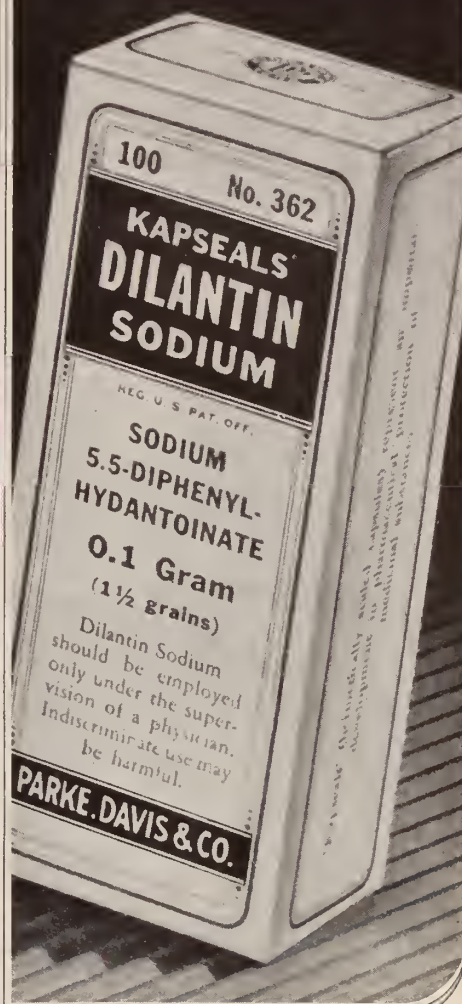


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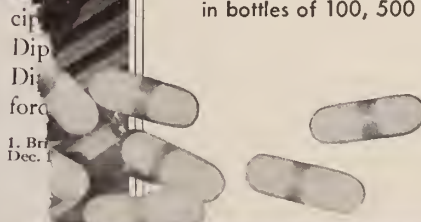
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\* The name 'Dilantin' Sodium designates the sodium salt of diphenyl hydantoin. 'Dilantin' Sodium was formerly known as 'Dilantin,' a term now designating the basic substance, diphenyl hydantoin. Dilantin Sodium is available as 0.1 Gram (1½-grains) and 0.03 Gram (½-grain) Kapseals, in bottles of 100, 500 and 1000.



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Accordingly, its health-giving qualities, due to its high content of Vitamin C, appreciable amounts of other vitamins, its mineral salts, citrates and sugar, recommend it to the medical profession as an additional and attractive means of increasing the dietary intake of these valuable accessory substances.

For several years the Citrus Commission of the State of Florida has supported chemical and nutritional studies on grapefruit in the laboratories of one of America's great universities. The figures given below are based on analyses of large numbers of grapefruit, conducted over a period of three years, together with data obtained from various sources in the literature of medicine and chemistry:

*Per 100 c.c. freshly expressed juice*

|                                |                   |
|--------------------------------|-------------------|
| VITAMIN C . . . . .            | 40 mgm.           |
| VITAMIN B . . . . .            | 20 Sherman units  |
| VITAMIN G . . . . .            | Present           |
| VITAMIN A . . . . .            | No data           |
| CALCIUM . . . . .              | 9 mgm.            |
| PHOSPHORUS . . . . .           | 15 mgm.           |
| CARBOHYDRATE . . . . .         | 10.1 gm.          |
| CITRIC ACID . . . . .          | 1.31 gm.          |
| POTENTIAL ALKALINITY . . . . . | 4.5 c.c. N/alkali |
| FUEL VALUE . . . . .           | 45 calories       |

American diet in general is markedly deficient in vitamins and mineral salts, and that deficiency disease is of frequent occurrence.

Counsel by physicians, dentists and dietitians to supplement the usual diet by the addition of grapefruit, should help to raise the present "minimum" intake of these accessory substances to that "optimum" which is requisite for buoyant health.

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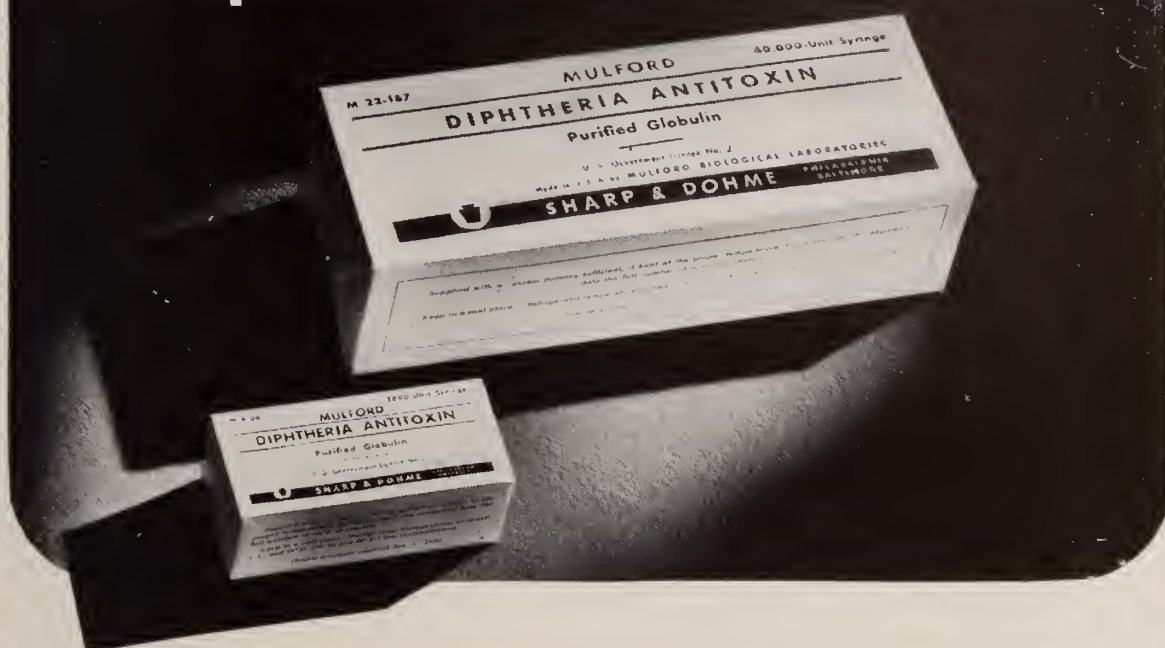
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Chart,<sup>1</sup> showing general tendency toward reduction in mortality rate as initial dose of diphtheria antitoxin is increased:

| Hospital | Average Primary Dose | Mortality Percentage |
|----------|----------------------|----------------------|
| A        | 9,000                | 7.81                 |
| B        | 13,700               | 3.84                 |
| C        | 15,000               | 5.43                 |
| D        | 16,000               | 4.40                 |
| E        | 17,000               | 2.87                 |
| F        | 22,000               | 2.66                 |

cipitated, Refined in  $\frac{1}{2}$ -cc. and 1-cc. doses; Mulford Diphtheria Toxoid (Anatoxine Ramon); Mulford Diphtheria Toxin for the Schick Test; and Mulford Diphtheria Toxin for Schick Test Control.

<sup>1</sup> Brit. M. J., 2:1132, Dec. 19, '31



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## GASTRIC AND DUODENAL SURGERY

RALPH A. GOWDY, M.D.  
Miami Beach

This paper only briefly covers this subject in order that lantern slides may be shown which I hope will be of more interest to most of you than anything I might say.

One needs offer no apology for harping on gastric lesions since cancer of the stomach takes the lives of nearly 40,000 people each year in this country. Dr. Margaret Warwick<sup>1</sup>, at the Minnesota University, held autopsies on 176 people who died from stomach cancer. She found that in 23 per cent of these cases the cancer had not extended beyond the walls of the stomach at the time of death. From her findings it is evident that a large percentage of these patients could have been cured by early surgery. At present surgical removal is the only known cure for gastric carcinoma and yet comparatively few receive surgical treatment. Most surgeons are willing to concede that duodenal ulcers should be treated medically unless perforation, obstruction or repeated hemorrhages have occurred.

Having decided that a duodenal ulcer falls into the small group which requires surgical treatment, the type of operation giving the best results is still much debated. Gastric resection is gaining ground for all types of peptic ulcer where operation is indicated. In perforated duodenal ulcer many surgeons still feel that it is best to close the ulcer and proceed no further. This may be proper when many hours have elapsed between perforation and operation or if the patient is in severe shock, but when the patient is in fairly good condition many feel it is not the best procedure.<sup>2</sup> Frequently these patients will not be well until a second operation is performed. On many occasions we do a pyloroplasty in the presence of perforation or even a gastric resection with no apparent operative shock, yet we do not believe gastric resection in the presence of perforated duodenal ulcer is usually the best operation. There are some cases of perforated duodenal ulcers in which gastro-enterostomy seems to be the only operation that can be used safely, but it should be used only when other operations are contraindicated.



CASE I, PLATE I

Perforated duodenal ulcer at head of pancreas causing obstruction. Age 38.



CASE I, PLATE II

Showing stomach one year after Billroth II type of resection. Patient well.

<sup>1</sup>Read before the Sixty-sixth Annual Meeting of the Florida Medical Association, held at Daytona Beach, May 1, 2 and 3, 1939.



CASE I, PLATE III

Showing stomach seven years after Billroth II type of resection. Patient well.

In dealing with chronic duodenal ulcer producing obstruction the operative procedure depends on conditions found at operation. If the obstruction is at the pyloric sphincter a pyloroplasty is the most desirable, while if the ulcer is quite far past the pyloric sphincter and perhaps adherent to head of pancreas a Billroth II would likely be best. In either location of ulcer if the patient is old and his condition not the best, a gastro-enterostomy would be the operation of choice.

In the hemorrhaging type of duodenal ulcer which requires surgical intervention, a pyloroplasty and removal or suturing of ulcer is usually the best operation. Finsterer<sup>3</sup>, however, does gastric resection in these cases. It is seldom necessary to operate during a severe hemorrhage.

In taking up gastric lesions one is confronted with a very different problem than when treating duodenal lesions. In general, we can say that duodenal lesions are medical problems and that only the complications require surgery, while gastric lesions are surgical problems. Of course, there are a few gastric lesions that will heal under medical treatment and remain healed. Because of these few medical cures a great many other gastric lesions are treated medically until the chance for a surgical cure has passed. The death rate

from surgical removal of lesions that might heal under medical treatment would be very small but the death rate from malignant gastric lesions treated medically is appallingly large. It is well known that the symptoms caused by early gastric cancer will subside under medical management and gastric analysis may show normal hydrochloric acid. The



CASE II, PLATE I

Deep ulcer high on lesser curvature, severe pain and many gastric hemorrhages. Age 65.



CASE II, PLATE II

Showing stomach 2 years after Billroth I type of resection. Patient well.



CASE II, PLATE III

Showing stomach 8 years after extensive resection by Billroth I type. Patient well.



CASE III, PLATE II

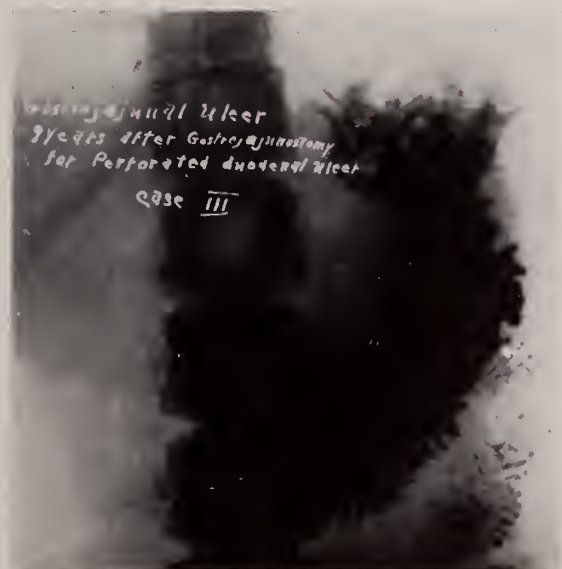
Showing stomach 2½ years after taking down of gastrojejunostomy and doing a Billroth I type of resection. Patient well.

patient may gain weight and the lesions may even heal by x-ray. During this period the only chance for a permanent cure by surgery may be lost.

Let me repeat that the only known cure for gastric carcinoma is surgery and in most cases surgery must take place while the lesion is still apparently benign. If a patient states that

no digestive disturbance was noticed before the age of forty and by roentgenogram a gastric lesion is found, it should be considered a surgical problem. Benign gastric lesions of all kinds usually start before the age of forty.

Most operations on the stomach fall into the types of operations known as Billroth I or Billroth II. Each of these types has many modifications some of which we will discuss. The Billroth I operation is especially effective in those people in whom sufficient gastric tissue can be removed and the proximal part of the stomach united to the duodenum without tension. This leaves the digestive apparatus in its physiological arrangement since the food still passes down the duodenum in its normal course. The Billroth I operation is not followed by jejunal ulcer as may happen occasionally with other gastric operations in which the stomach empties directly into the jejunum. The sleeve type of stomach resection is useful in removing a large tumor from the fundus. If the pyloric end of stomach is obstructed with a lesion that cannot be removed a gastroenterostomy will give relief and possibly at a later date the obstructive lesion can be removed.



CASE III, PLATE I

Showing ulcer in stoma of gastrojejunostomy done for perforated duodenal ulcer nine years before. Woman aged 36, very much underweight.





CASE V, PLATE I

Showing stomach 15 years after gastrojejunostomy had been done for perforated duodenal ulcer and 9 years after gastrojejunostomy had been taken down for stomal ulcer and a pyloroplasty done. Large ulcer on lesser curvature with gallbladder firmly adherent to ulcer.

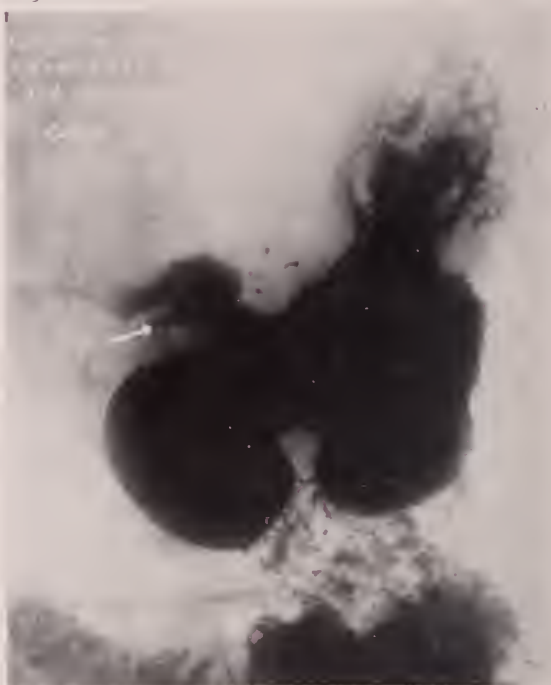


CASE V, PLATE II

Showing stomach 1½ years after extensive resection by Billroth I type of resection. Patient well. Age 70.

By far, the greater number of stomach operations fall into the type of operation known as Billroth II. There are many modifications of this operation but in all of them the distal part of the stomach is closed or removed and the proximal part is attached to the jejunum so that food passes from stomach to jejunum without passing through the duodenum. In most cases the original Billroth II operation seems better than any of the modifications. A majority of surgeons, however, employ the Polya modification, or some modification of a Polya. When the original Billroth II does not seem desirable I like the Hofmeister modification of a retrocolic Polya as it leaves a smaller opening through which the food must pass to the jejunum somewhat similar to the Billroth II.

In presenting this paper it is my desire to again bring up for discussion stomach and duodenal lesions. Until we can lower the death rate from stomach cancer we must continue to harp on gastric lesions. It is our duty to impress on the public that gastric lesions are serious unless proved otherwise, especially so in people over forty years old. Every person past this age having digestive trouble should have gastro-intestinal roentgenograms. This would enable us to locate



CASE VI, PLATE I

Showing stomach with large ulcer prepyloric on lesser curvature with great deformity to duodenum, ulcer found 15 years before by x-ray; would not consent to surgery until obstruction developed. Age 65.

many lesions early when surgical removal might give a permanent cure. In doing gastric and duodenal surgery I use only absorbable suture material. Stomach or intestinal clamps are not placed on the tissue to be left. It does not seem reasonable that a clamp can be used



CASE VI, PLATE II

Showing stomach 2 months after extensive resection, Billroth II type. Patient well.



CASE VII, PLATE I

Showing large carcinoma in fundus; no metastasis could be found. Age 60.

on the stomach or intestine for thirty minutes without doing permanent damage. Blood transfusions, Wangenstein drainage, intravenous normal saline and dextrose are all used following this type of surgery.

All of the lantern slides to be shown are from private cases most of which have been followed for several years. By these slides I will try to demonstrate different types of gastric and duodenal operations and show results following these operations.

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#### DISCUSSION

*Dr. Walter C. Jones, Miami:*

Doctor Gowdy has presented a very interesting paper to us. However, I think we have taken on our hands this morning a subject which is so great that it is impossible for us to get more than a brief summary from it.

In the first place the discussion of this paper of Doctor Gowdy necessarily must divide itself into two distinct divisions as to the indications for handling duodenal and gastric lesions. The medical and surgical management of these cases are so entirely different that



CASE VII, PLATE II

Showing stomach 6 months after extensive resection of fundus. No recurrence in stomach. Metastasis in liver. Free from gastric pain after operation.



discussing one subject without differentiating it would be impractical. Also in discussing duodenal ulcers we must consider them in both the acute stage and the chronic stage.

We have had friendly discussions with medical men on this operable question and I think we now agree on a more conservative management of these duodenal lesions unless we have rather definite indications for surgery in the duodenum. This is still a very debatable subject, however, from the surgical standpoint.

In ruptured peptic ulcers, whether to do the simplest type of technique or simple closure with omental transplantation or whether to do more radical surgery is to be decided in the individual case.

For about ten years I have been getting a little more radical in my treatment of acute ruptured ulcers, and I think advantageously so. My first experience with them was some ten years ago. At that time I had a case, a woman with acute ruptured ulcer which was overlooked for some twenty-four hours. I operated and found an ulcer on the anterior wall, marked induration as you would expect with plastic exudate in and about the area. I attempted to do what seemed most easy—to close it and put some omentum over it, but my attempt was futile. I felt that it was impossible for me to accomplish anything in that case, so I proceeded to do a resection of that ulcer using the Judd type of resection. Much to my surprise the patient ran an uneventful course. Naturally such procedures in surgery make us stop and think. We have been doing this on practically all of our ruptured ulcers for the last ten years.

This question will take considerable time if we go into details, but I think we have been entirely too conservative in the management of ruptured peptic ulcers. I think our ruptured peptic ulcer patients die not from surgery but because we did not accomplish a closure. They die, as you look back over your cases, five or six days after operation.

In the chronic type of duodenal ulcer, I think, obstruction of course is the chief indication for surgery. In that type of case the question of what is best to do is an individual problem for study in each case.

I do want to stress one thing that has not been brought out in the obstructive type of ulcers. These patients must not be operated upon until they have been thoroughly prepared. Thorough preparation is not a twenty-four hour proposition. It takes weeks to get this stomach back to normal or to the proper state for any surgical procedure you may anticipate. I think if we don't properly prepare these chronic cases we will be defeated before we begin our surgery.

The type of operation that we will do on these particular cases is something that we cannot go into extensively now. I think Doctor Gowdy's discussion of it has been very clear. I am in favor of the Finney type of operation for mobile cases. And I think that the Horsley type is quite satisfactory in some cases that are not quite so mobile. I don't feel that the Judd type has been entirely satisfactory.

I am beginning to believe that we are going back to the gastro-enterostomy which was in vogue some twelve to fifteen years ago, especially in these obstructive cases.

I feel that the gastroscope is going to be a great deal of help in some of these gastric cases. We will not have to open up the abdomen to differentiate between inflammatory and malignant cases. But where there is any question, gastric surgery is mandatory. I think resection in these cases of the lesion itself and necessary portion of the stomach is the thing we must do. The question of cancer in a gastric lesion is one we must not forget.

#### *Dr. Ralph A. Gowdy, (Concluding):*

In regard to the gastroscope I would say that it is very important in helping us to make a diagnosis of certain stomach conditions especially gastritis, and no doubt will be used extensively from now on. To make

a positive diagnosis between chronic benign gastric ulcer and carcinomatous ulcer during the early stages of the latter is impossible by gastroscope. It can only be done by microscopic examination of the tissue after removal by surgery. If we delay surgery in gastric lesions until we can be sure they are malignant by gastroscope or x-ray the chances for cure by surgery will be very small. The only time the probability of a permanent cure for gastric carcinoma is great is when it still is apparently a benign lesion. For this reason I advocate surgery on gastric lesions which do not heal and remain well by x-ray after a short period of medical treatment.

I recently saw a review by Dr. George B. Eusterman, of an article written by Dr. Rudolph Schindler on Gastroscopy. Doctor Eusterman says: "Schindler's enthusiasm for this procedure is understandable and pardonable. On the other hand, he frankly informs us that ulcers of the duodenum and pylorus cannot be seen gastroscopically and that the lesser curvature of the antrum often remains hidden from view. Yet it is at these very sites that the vast majority of gross, chronic, benign and malignant lesions of the upper digestive tract, so readily demonstrated by the experienced roentgenologist, are located. The reviewer is also of the opinion that differential diagnosis between a chronic benign gastric ulcer and a carcinomatous ulcer (not ulcerating carcinoma) especially in the earlier stages of the latter, is impossible gastroscopically in many instances."

Gastroenterostomy seems to be especially desirable in obstructive duodenal ulcer of long duration. In hypertrophic pyloric obstruction in babies the Rammstedt operation gives almost instant relief. Last Wednesday I did a Rammstedt operation on a baby. The baby left the hospital on Sunday apparently well.

I agree with Doctor Jones that the complications of duodenal ulcer require surgery and in most cases should be treated medically until obstruction, perforation or repeated hemorrhages have occurred. I have also encountered some difficulty with the Judd pyloroplasty in getting the stomach to empty as quickly as it will with a Billroth I resection or some other type of gastric operation.

I am sorry time did not permit showing all of the slides.

### THE IMPORTANCE OF CASE RECORDS RELATIVE TO THE CANCER PROBLEM

R. L. ELLISTON, M. D.  
Ft. Lauderdale

The etiology of cancer continues to challenge scientific endeavor. However, when one reviews the observations made, and the results of animal experimentation of the last few years, he cannot help but be impressed with the progress being achieved by those devoting their time to this important subject. It is probably well that we pause occasionally and ask ourselves if we, as physicians, are doing all in our power to carry on our part in regard to this major problem.

In 1932 McFarland and Meade published a paper on the genetic origin of tumors supported by their simultaneous and symmetri-

Read before the Sixty-sixth Annual Meeting of the Florida Medical Association held at Daytona Beach, May 1, 2 and 3, 1939.



cal occurrence in homologous twins. They reported a number of cases showing congenital defects, a variety of systemic diseases, and neoplasms. Their studies seemed to indicate that if a tumor develops in an identical twin, in a given organ at a given time, the same type of tumor will develop in the other twin in the corresponding organ at, or near the same time.

Obviously in a study of this kind it is necessary that one deal with true identical twins. Since only one-fourth of all twins are identical, and since but one identical twin birth occurs in 360 births, material of a pathologic nature in this group is scarce. By studying the character of the placenta one can say definitely whether the case is, or is not, one of identical twins. In studying a large number of twins Greulich found 25.4 per cent to be identical. Guttmacher, in his examination of placentas alone, found 25.7 per cent to be identical.

Homologous twins are considered to be the product of one ovum and one spermatozoon, which in splitting in very early embryonic life, give to each new individual half, or nearly half, of the chromosome and gene structure. If this is so, it is logical to suppose that each of the new beings will be subjected to a considerable degree, to the same inheritance factors. Some cases have been reported which give strong evidence in support of this theory. In 1936 Mumford and Linder reported an instance of carcinoma of the breast in homologous twins. These tumors developed within a few months of each other, in the left breast of each, when they had reached the age of 91. Benedict reported a case of retinoblastoma in the corresponding eye of each member of homologous twins at the age of four years. Last year Phillips of the Mayo Foundation, reported a case of bilateral mammary carcinoma in identical twins. In this case carcinoma developed in the right breast of the first twin three years before it occurred in the same breast of the second twin.

In the study of certain families the incidence of cancer is found to be relatively high. One of the most outstanding cancer families in this country, was first reported by Warthin in 1913, and again in 1925, and by Hauser and Weller in 1936.

The paternal founder of this family died

about 1856 at the age of sixty, with what was thought to be cancer of the stomach or intestines. In an analysis of the descendants of this parent, fifty-four deceased, who attained the minimum cancer age of twenty-five years, 35, or 64.81 per cent, developed cancer. Of the 305 descendants, 174 attained the age of twenty-five years, and of this number, 41 developed cancer, an incidence of 23.6 per cent. If the 25 members of the two branches of the family in which malignant disease has never appeared, and who have reached the cancer age are excluded, the incidence of cancer is 27.5 per cent.

Hauser and Weller have pointed out that an inspection of the entire family record gives the impression that there is a decreasing incidence of cancer in the younger generations, which seemed to them to be more apparent than real, and that not until the full effect of age becomes known, with respect to the third and fourth generations, can the question of a decreasing incidence of cancer be determined. They contended that if there was a diminishing incidence, it would argue for and not against an intrinsic predisposition to malignancy, as evidenced by the fact that cancerous members of the third generation have to a marked degree, failed to leave issue, and that of the entire family group, 15, or 36.58 per cent of the 41 cancerous individuals have died without leaving issue.

It is also interesting to note in this family the tendency of marked organ susceptibility, as shown by the fact that of the 43 primary cancers in the 41 individuals, 26 have occurred in the gastro-intestinal tract, and 15 in the endometrium, which is in contrast to only one in the breast and one on the skin of the nose.

In a recent issue of *Surgery, Gynecology and Obstetrics*, Holmar called attention to the possibilities which lay open to us in a careful study of the genetics in relation to cancer. He cited six so-called cancer families, and suggested that it would be worth while to have a central library where cases of cancer with definite genetic aspects could be collected for further study. In the next issue of the same journal, Lockhart-Mummery wrote a paper in which he emphasized the fact that the profession had not paid sufficient attention to the problem of genetics in cancer.

The biological evidence in support of the

hereditary theory of cancer development, contributed by Maud Slye of the University of Chicago, is most interesting. By 1913 she had accumulated, in four years, a stock of about 5,000 mice of known ancestry. It was with this stock of mice, in which neoplasms had begun to appear spontaneously, that she started her now famous studies on the relationship of heredity to spontaneous cancer. During the course of her extensive breeding experiments, she has isolated strains of mice, which regardless of environmental influences, have never had cancer. In contrast to this she has developed strains which show a 100 per cent incidence of cancer. She has also isolated strains which show a marked tendency to the development of special types of tumors and still other strains which show a 100 per cent organ susceptibility to tumors.

According to a 1937 report Maud Slye has performed necropsy on 140,000 mice, in which she has observed 100,000 cancers. She contends that malignancy is transmitted as a localized recessive character, and that each type of malignancy is a unit character capable of suppression by a dominant. For example, she believes that there is one unit recessive character for carcinoma, one for sarcoma and one for leukemia, and that the location factor which determines where malignancy shall occur is transmitted as a recessive character capable of suppression by a dominant. Thus there is one unit recessive character for each location of malignancy, such as the breast, lungs, abdominal wall, and so forth, and the tendency to carcinoma, sarcoma or leukemia differs in only one gene from the tendency to noncarcinoma, nonsarcoma or nonleukemia. Hence the genetic pattern for a malignant tumor and its location each requires a unit recessive, one for the malignancy itself, and one for its location.

According to Maud Slye's investigations, susceptibility and nonsusceptibility to spontaneous neoplasms in mice depend absolutely upon genetic factors. At present we do not possess sufficient evidence to make a similar claim in regard to the development of neoplasms in man. However, since man and mouse are governed by the same biologic laws, it seems logical to assume that susceptibility and nonsusceptibility in the human race, do depend on such factors.

Many investigators have studied the mechanism of tissue repair in wound healing. Notable among these research workers is Carrel. He was able to show by his experiments, that a wound free from debris of tissue and blood clots, and absolutely protected from outside irritation, does not heal. He believes that every mild irritant brings about the invasion of leukocytes, which in secreting so-called "trephones" induce cicatrization.

Murphy was able to show that after an animal had been exposed to x-rays, lymphocytes divide in its serum more readily than in that of the untreated animal. Carrel attributes this effect to the destruction or stimulation by x-rays of lymphocytes and the liberation of "trephones" in the plasma.

In the laboratories of the Institutum Divi Thomae of Cincinnati, Loofbourow, Dwyer, Sperti and others have isolated metabolic stimulating factors from cells. In their experiments they have shown that injured cells secrete substances which stimulate growth, respiration and the utilization of sugars. Not only have they shown that there are proliferation-promoting and inhibiting substances in tissues and in cell cultures, but that proliferation-promoting substances are elaborated by injured living cells as a definite response to injury. The most potent preparations of the proliferation-promoting substances were produced by prolonged injury to cells before death took place. They therefore believe that these substances are elaborated by living cells during injury. These substances are effective in such small quantities as to suggest that their action is hormone-like. They believe that in the case of benign and malignant tumors it is reasonable to postulate that the fundamental mechanism involved is the collection in abnormal concentration of metabolic stimulating factors produced by cells as a result of irritation or injury of long standing.

Recently Bittner and his co-workers of the Jackson Memorial Laboratory, Bar Harbor, Maine, have performed some interesting feeding experiments on mice born to females showing a high breast tumor incidence. These young mice were removed from their mother as soon as recorded, and fostered by females of a line showing a low breast tumor incidence. Of these fostered females and their



progeny 23.1 per cent developed breast tumors, while the incidence of breast tumors among the control mice was 83.2 per cent. Other series gave similar results. They conclude that their experiments would tend to indicate that some influence is transmitted through the mother's milk, which is of prime importance in determining the incidence of breast tumors. The incidence of breast tumors may be significantly decreased by fostering females of a high breast tumor stock by low tumor stock mothers.

In setting forth these observations and this experimental evidence it has not been my purpose to uphold any particular theory as to the cause of malignancy, but due to such interesting and encouraging findings lending hope to the solution of this problem, I wish to encourage a more extensive, united effort on the part of the medical profession in gathering and recording data on those individuals suffering and dying of this disease. It is especially urged that the forms used in recording such data be of a uniform type to make this work more simple, efficient and valuable when a study of these records is undertaken.

In order that we may more nearly parallel important findings in animal experimentation, it is proposed more space be given pertinent questions than is now found on most of our existing forms. Space for an adequate family history asking for the names of the individuals with their address, or place of death, and cause of death, would seem necessary. A question asking for previous infection, irritation or injury at the site of the lesion, should appear on such a form. It would also seem desirable that consideration be given the character of the early nourishment of the individual. By all means these forms should be uniform.

I realize some of the difficulties attending an effort to unify our record system. In the summary of the report of the Committee on Clinical Records of the American Hospital Association of 1937, in reference to a questionnaire sent to 231 widely distributed hospitals, the following was taken:

Twenty-seven per cent replied that they had found the record forms suggested by the previous committee useful; twenty-one per cent had not found them useful; and six per cent replied that they had not seen these forms.

Seventeen per cent had adopted some of these forms; thirty-five per cent had not adopted any of these forms; and forty-six per cent did not make any reply to this question.

Such a discouraging report gives us a fair idea of the probable prevailing conditions of today. This should stimulate our efforts to correct this situation, which would appear most necessary. It is therefore proposed that a committee be appointed for the purpose of studying forms for obtaining records of cancer cases, and to obtain their adoption throughout the state; this committee to work with the committee on cancer control and the committee on clinical records of the American Hospital Association, and the American College of Surgeons.

It is further proposed that copies of such forms when adopted, be sent to each county medical society within the state and their cooperation solicited in this work, that they be encouraged to use these forms in making records of all cancer cases, both institutional and noninstitutional, such records to be properly filed at designated central stations.

Should such a unified system of obtaining data on malignant cases be adopted generally, much valuable information which is now being lost could be grouped in such a manner as to afford ideal conditions for study, thereby assisting in the solution of a problem, which has thus far remained unsolved.

### *811 Sweet Building*

### DISCUSSION

*Dr. E. M. Hendricks, Ft. Lauderdale:*

I want to thank Doctor Elliston for his timely appeal for a cancer registry.

When Maud Slye first propounded her theory and first published her work, hardly any man in the medical profession accepted her findings as facts. There was much critical discussion some even approaching ridicule. However, her work has now advanced to such a place that we can no longer disregard the results. She has shown that a mouse can be bred on demand which will die of cancer in any desired portion of the body. The proof of her hereditary theory of cancer is so clear cut that any other conclusion seems untenable. She has also found that she can breed cancer out of her mice in about three generations. This is of vital importance.

There has been little investigation of the hereditary factors of cancer as they are applied to humans. Here and there a family has been selected for intensive study but the data obtained have been too meagre to draw any definite conclusions. Maud Slye in her life has studied enough generations of mice which if applied to humans would carry us back almost to the Pharaohs. If we started now, our investigations would not be finished by us nor our grandchildren, but a start must



be made sometime as each delay projects still further the time of the final solution of this problem. If there is a definite hereditary factor for the production of cancer in the human beings, let us know it, and if there is a eugenic solution to the problem let us find it. If Maud Slye can breed cancer out of her mice in three generations, is it not probable that the same can be done with human beings? This would certainly be a remarkable piece of work.

In the first place we should attempt to obtain adequate case and family histories. The information obtained from several generations may be sufficient to enable us to correlate the findings of experimental animal breeding with the human problem and so show us a definite plan for the elimination of cancer. There will be a certain expense involved but the value of the information obtained will be far greater than the small amount of money entailed in the operation of a central registry. Cooperation of the entire medical profession is of course essential. This may be difficult to obtain; the gradual realization of the importance of the work will aid materially in getting this cooperation.

Maud Slye has written that she can breed out as well as breed in cancer. Our Florida registry will show whether this is possible with humans.

#### *Dr. F. K. Herpel, West Palm Beach:*

I appreciate the opportunity of discussing Doctor Elliston's paper. I think it is very timely.

I will not go into the difficulties of such a program, but I am sure you all realize that we will have to record our experiences in cancer clinics, establish something similar to the pathological library of Johns Hopkins University founded many years ago by Doctor Bloodgood.

Certainly it is very difficult to get follow-up records on patients examined. The same thing will apply to any attempt to get statistical records. Patients leave without adequate records being obtained.

In any customary group of 100 white females, about 13 of these will die of cancer under our present set-up. In a combination group of 100, ten will die of cancer. It is estimated that there are probably 500,000 people afflicted with cancer in the United States at any one time. Cancer has become the second cause of death. Also in 1936 it was established that we had 150,000 deaths as a result of carcinoma or malignant disease. Under the age of 55 cancer deaths are more frequent in women, whereas in ages over 55 they are more frequent in men. White women have a lower death rate than colored women, white men a higher death rate than colored men.

Many facts come out with regard to cancer which will require extremely careful records.

There has been a definite increase certainly in the incidence of cancer of the breast, also a fall in incidence of cancer of the cervix. We know the occurrence of cancer in the breast is more frequent in women who have not nursed children than in women who have nursed children. Cancer of the cervix is more frequent in women who have borne children and have torn cervixes than in women who have never been pregnant.

What is the consequence of these findings in view of the lowering birth rate in this country? We are having more sterile marriages in this country and they are increasing with the decreasing birth rate. Naturally there are fewer women out of every 100 who nurse children, and fewer who suffer injury to the birth canal. None of this can be determined from our present statistics.

Dealing as I do with the treatment of malignant disease, I realize only too well the difficulty attendant upon securing adequate records. In addition to the comments by Doctor Hendricks, not infrequently we have cases in which it is not desirable to acquaint the patient with the true significance of his disease.

I think I must say that in a survey of the American College of Surgeons in 1933 and 1934, they did obtain definite case histories in 25,000 patients with breast cancer. Some lived five years after treatment with no recurrence of symptoms. I think if we all keep that fact in mind despite the fact that we are having 150,000 people die every year from cancer, we will realize that our efforts are worth while.

As Doctor Elliston has brought to our attention, I think we all should bear in mind the necessity for adequate records in attempting to check where we are going in this problem of the treatment of cancer.

#### *Dr. L. L. Whiddon, Ft. Pierce:*

The essayist well said the cause of cancer is still baffling organized medicine and the world. It is very embarrassing to me to continue to come up and say that sugar is the cause of cancer when I base my statement only upon empirical observations. However, the man who first decided and said what was the cause of infection in motherhood after childbirth had to depend only upon such observations.

Lord Kennenger, of London, Professor of Medicine, not only said that sugar caused cancer, but he showed by graphs that when sugar consumption came up cancer also came up from 1849 to 1928 which was the end of the graph. In 1914 when sugar was taken away from the civil population of England, sugar consumption went down and the incidence of cancer went right down with it. It stayed there until 1919 when sugar was again given to the people. When sugar consumption came up, cancer also came up. When we increase our sugar consumption, we are sure to get cancer in the same ratio.

About three years ago I was in New York and accidentally met Doctor Gratz, Professor at Columbia University. He took me out to lunch and he saw me put saccharine in my tea instead of sugar. "Diabetes, Doctor?" he asked. I said, "No, but I think sugar is the worst food in the world." He said, "Doctor, you are right." I said that I thought it was even the cause of cancer. He said I was exactly right. I said I had told the profession in Florida that it was the cause of cancer and they laughed at me. He said to let them laugh, that they would eventually come to the same conclusion.

He said Doctor Deeks, the president of the American Fruit Company, "put him wise" several years ago, and immediately he checked 100 cases of cancer at the Mt. Sinai hospital and that day sugar and white bread went out of his home. He said he and Doctor Deeks planned to write a book on sugar as the cause of cancer but Doctor Deeks died and he had not had time. Doctor Deeks was president of the American Fruit Company with \$40,000,000 invested in sugar, and at the same time he was going to help Doctor Gratz write a book condemning sugar!

Granulated sugar is granulated poison. This statement was made by Doctor Banting of Canada. I could stand here and talk all afternoon upon laboratory reports of sugar investigations but there is no time. We caused tumors in rats by feeding them sugar. I don't doubt that Maud Slye bred rats with cancer, but she did not breed cancer into rats. She just bred the susceptibility in them. Sugar does not cause 100 per cent of cancer, but it does cause a lot of people to have cancer who would not have it if they did not eat sugar.

Sugar causes many other conditions. I am willing to say it causes almost all upper respiratory affections.

I went off sugar seven years ago, and I want to tell you I had influenza six times in my life and common colds five to ten times a year, but in the last seven years, practicing complete abstinence from sweets of all kinds in the way of foods, I have not had one bad cold in the entire seven years!

## WATER AND SALT METABOLISM

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It is hard to think of a phase of human physiology which more vitally concerns all phases of medicine than does fluid balance. It particularly concerns the surgeon and the internist. What is the practical significance of fluid balance? It simply means the balance that must take place between the total intake of water plus water liberated by metabolism and the output of water resulting in the maintenance of a fairly constant level of the body water content.

Gamble<sup>1</sup> states that the cell itself needs no water because it makes its own in excess in its metabolism, thus pointing out that water balance is an extracellular problem. He states that about 5 per cent of the body weight is made up of blood, 15 per cent of extracellular fluid and 50 per cent of intracellular fluid. The margin of safety for variation of fluid intake and fluid loss is in the interstitial fluid which keeps the plasma fairly constant in volume. This remains true until practically all of the interstitial fluids have been lost. He also pointed out that the osmotic pressure of extracellular fluids is due almost entirely to the sodium, chloride and bicarbonate ions and that the volume of the extracellular fluids is dependent on the amount of sodium ions in it.

Water is obtained from two principal sources: (1) fluids drunk, 800-2000 cc. and (2) food consumed which includes water derived from the food itself and the water of oxidation. This amounts to about 1000-1500 cc. daily. Water is excreted through three main channels: (1) water of the urine, 1000-1500 cc. per day, (2) water of the stool, 150 cc. per day, and (3) water of vaporization, 1000-1500 cc. per day. This includes water lost by the skin and lungs.

In considering fluids available from food, it is well to remember that in the case of many acutely ill patients and many surgical patients food may for some reason be withheld in which case the water available from this source comes from tissue oxidation only, and

amounts to about 500 cc. daily. For practical purposes, as suggested by Coller<sup>2</sup>, the latter may be disregarded. The fluid output in post-operative patients and in certain acute illnesses should allow for a 1500 cc. output by urine a day because it is by this means that waste materials in solution are removed from the blood. A normal kidney functioning at its maximum excretory power can remove the waste materials necessary in about 500 cc. of urine in twenty-four hours, but we do not always know the kidney function of these patients, so probably it is wise, as advised by Maddock and Coller<sup>3</sup>, Nesbit<sup>4</sup>, Gamble<sup>1</sup>, Solomon<sup>5</sup> and others, to maintain a 1500 cc. urinary output each 24 hours. Coller<sup>2</sup> has pointed out that a kidney which will concentrate only to about 1.01 requires a minimum of 1500 cc. to excrete the wastes put out normally by the kidney in a day. It should be remembered that the body first uses water for every other purpose and then gives the balance to the kidneys.

A source of constant loss, which amounts to about 1500 to 2000 cc. in a sick patient, is evaporation for heat regulation. This is called the insensible loss of water and is not water lost by sweating. This loss is from the skin and lungs. No salt is lost by this process.

From this we see that for the average post-operative patient, not very ill, we need to give 3500 cc. of fluid daily. This does not allow for the patient who has previously experienced abnormal loss of fluid from one source or another. The history is very important in determining whether there has been any lack of fluid intake or abnormal loss of fluid during the illness. This must be taken into consideration in planning to restore the fluid balance. A patient who is severely dehydrated from whatever cause is a poor risk until properly rehydrated. Symptoms of dehydration are dry skin and tongue, sunken eyes, hollow cheeks, scanty urine or anuria. Coller's<sup>2</sup> work on dehydration is interesting and instructive. He put a group of normal individuals on a very low fluid intake and noted that the loss of weight was 5.7 per cent of body weight, that the urine was decreased in volume, that the nonprotein nitrogen was increased, that the blood became concentrated and that on the fourth

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Read before the Duval County Medical Society, Jacksonville, January, 1939.



day albumin and red cells appeared in the urine. These patients were given 6000 cc. of water and only put out 100 cc. of urine during the day in which this fluid was administered. This important point shows that a dehydrated patient must receive 3500 cc. of fluid for his daily average need plus 6 per cent of his body weight as additional fluids, thus making a total requirement for the average man of between 7000 and 8000 cc. for the first 24 hours.

After the dehydration has been corrected, the future plan must include the basic intake of 3500 cc. of fluid daily plus any amount lost by vomiting, estimation of drainage from intestinal fistulas or profusely draining wounds, severe diarrhea, profuse sweating, Wangensteen drainage and the like. The failure to consider these losses will often lead to a gradual dehydration with alkalosis or acidosis in spite of an intake of 3500 cc. of fluid daily.

Taylor<sup>6</sup> reports a patient who following operation for ruptured ulcer developed alkalosis and died. The patient was given 3500 cc. of 5 per cent glucose in normal saline solution daily but he had duodenal siphonage or Wangensteen drainage and had been losing 3000 to 8000 cc. of fluid through the duodenal siphonage for several days. When the condition was recognized and the carbon dioxide combining power of the blood was brought back to normal it was too late. The patient, having sustained the alkalosis for too long a period, died.

This brings up the problem of what alkalosis is and what its causes are. Alkalosis may result from hyperventilation of the lungs with its resultant excessive removal of blood, carbon dioxide, excessive ingestion of alkalis, pyloric obstruction or high intestinal obstruction which results in the vomiting of large amounts of chloride in excess of sodium. It also occurs in a small percentage of cases of diarrhea. Wright<sup>7</sup> describes the symptoms of alkalosis as loss of appetite, headache, irritability, nausea and vomiting. There also may be aching pains, twitching muscles, flushing, and weakness and the patient may pass into a state of prostration. Later tetany may, and often does, occur. Breathing is slow and the pulse rapid. If there has been no abnormal loss of fluids, the urine is al-

kaline and is increased in amount. Signs of renal damage such as the presence of albumin, casts, red and white cells frequently appear in the urine, and later evidence of renal insufficiency may occur with an increase in urea and nonprotein nitrogen. Death may come in coma apparently largely as a result of the uremia. For example, in a case of high intestinal obstruction, there is an increasing loss of chloride and fluid which causes an alkalosis and dehydration. Often in spite of this, there will be an acid urine and acetone in the urine. Wright<sup>7</sup> explains the acid urine by stating that the bicarbonate ion must be retained by the body fluids to replace the chloride ion and thus maintain the proper osmotic pressure of the blood. Acetone appears in the urine, according to Standard<sup>8</sup>, because of starvation ketosis.

In obstructions low in the intestinal tract the tendency to alkalosis is not so severe, but there is a marked dehydration plus a loss of sodium chloride and a starvation ketosis. Standard<sup>8</sup> points out that physicians often feel comforted by the absence of vomiting in intestinal obstruction. This is not warranted, however, because the mere absence of vomiting is no insurance against dehydration and acid-base derangements. The fluid that is contained in the intestinal tract from overdistention in paralytic ileus cannot be absorbed and must be considered outside of the body. The treatment of these intestinal disorders is well established and consist of the overcoming of dehydration, the giving of sufficient sodium chloride and the overcoming of ketosis with glucose. These measures save many lives.

Acidosis occurs in starvation, from ingestion of large amounts of acid-producing salts, from diets designed to produce ketosis, from nephritis, severe diarrheas, diabetes and fistulas of the duodenum and jejunum because of the loss of very alkaline fluids. It should be remembered that severe dehydration often accompanies acidosis. It is interesting to note to what extreme dehydration in association with diabetic acidosis may occur. Root<sup>9</sup> reported a case of diabetic coma in which the patient was anuric and almost pulseless but recovered after having received 12000 cc. of normal saline and approximately



1200 units of insulin in a period of twelve hours. The patient did not begin to urinate until the last thousand cc. of normal saline was given. This is a very important point to those of us who treat diabetes. The water and the salt must be replaced in addition to metabolizing the glucose before diuresis can be expected and the acidosis corrected. Gamble<sup>1</sup> in his excellent work recently proved that the giving of sufficient sodium chloride plus the metabolizing of added glucose will correct acidosis. Root<sup>2</sup> made a very practical point when he stated that the giving of glucose to a diabetic in coma with a high blood sugar is unnecessary and only clouds the picture. The glucose level is already very high and added glucose is certainly of no value. It cannot act as a diuretic in the face of an existing dehydration. Acidosis is treated by correcting dehydration and the giving of sodium chloride and glucose to combat ketosis. In diabetic acidosis an excessive amount of glucose is already present and no more need be added. Though the use of normal saline solution is so essential in the treatment of dehydration, acidosis, and alkalosis, it should not be given indiscriminately. Collier<sup>3</sup> demonstrated this quite vividly in a study of ill surgical patients. One series received 3500 cc. of 5 per cent dextrose in normal saline solution and gained weight. A second series of cases received 3500 cc. of 5 per cent glucose in Ringer's solution daily and gained weight but to a lesser extent. A third series of cases received 3500 cc. of 5 per cent glucose in distilled water daily for three days and lost weight. This loss of weight was due to a loss of body tissues which were consumed as food. None of the entire series of patients was losing fluids in any abnormal manner. He also noted that those who were transferred from normal saline to 5 per cent glucose in distilled water promptly excreted an excess of urine above the total intake for twenty-four hours. Patients who do not lose any fluid through excessive perspiration or other abnormal channels lose very little sodium chloride, probably not over 0.2 gram a day; therefore, there is no indication for the administration of sodium chloride to these patients. That sodium is a factor in the retention of water was brought out by Mason<sup>10</sup>

when he gave normal individuals 36 grams of sodium bicarbonate daily for three days and produced an average gain of 2.28 pounds in weight. Straus<sup>11</sup> found that in toxemias of pregnancy the plasma proteins were often at, or below, the edema level and that the edema could be precipitated or aggravated by the intake of sodium bicarbonate or sodium chloride. On the other hand, the edema could often be controlled or eliminated by the restriction of sodium in the diet. The excessive use of saline solution may lead to edema, degenerative changes in kidney and heart muscle and edema of the lungs. The first sign of too much sodium chloride is usually dependent edema. However it should be remembered that loss of plasma proteins from profuse drainage of a wound or burns may cause edema which can be corrected by replacement of plasma proteins with blood transfusions. This edema is not caused by an excessive amount of sodium chloride but by a deficiency of plasma proteins.

What should be our guide as to how much fluid to give and what kind? It is always best to give the proper amount of fluid by mouth unless there is some contraindication to it. We must give 1500 cc. to allow for 1500 cc. of urine and 2000 cc. to allow for evaporation from the skin and lungs. This is sufficient provided there has been no abnormal loss through vomiting, diarrhea, sweating, or, as in the case of diabetes, excessive loss through the urine. These losses must be estimated or measured whenever possible and this amount added to the normal required intake. This is not sufficient if the patient has been losing excessive amounts of fluid and having an inadequate intake, but the deficiency must be taken into consideration and the fluid intake proportionately increased. A patient who is definitely dehydrated should receive the normal body fluid requirement of 3500 cc. plus fluid equivalent to 6 per cent of his body weight during the first day. A patient who has had an operation of thirty minutes' to one hour's duration, and who has been in good water balance prior to that time, according to Maddock and Collier<sup>8</sup>, will lose about one liter of fluid from vaporization, loss of blood, urine, and vomiting during the operation and recovery

period. This patient should receive 1000 cc. of 5 per cent glucose in normal saline solution immediately and then 3500 cc. of fluid daily, preferably 5 per cent glucose in distilled water. If he lost fluids by abnormal channels there would also be a loss of electrolytes which should be replaced with normal saline solution. It is desirable to keep an accurate account of both the output of urine and any vomitus or drainage and an accurate record of the intake. It is particularly important to know the output from the stomach as in the case of Wangenstein drainage. Only in this way can one assure his patient of proper water balance. To give the total requirements as normal saline would be to invite edema and salt shock after a few days.

In the case of a patient with marked dehydration and chloride loss from the intestinal tract 5 per cent glucose and normal saline should be given until the salt content has returned to normal. The amount required may be enormous, running as high as 8000 to 12000 cc. on the first day. Five per cent glucose in Ringer's solution is equally valuable. Once the chloride has been restored to normal, the dehydration corrected, and there is no further loss of electrolytes, 5 per cent glucose in distilled water should be used.

If there is an acidosis or an alkalosis, how can sodium chloride and glucose alone correct it? The glucose helps to metabolize the fats and prevent ketosis. After dehydration has been corrected, the sodium chloride acts by replacing the bicarbonate ion with the chloride ion and the excretion of excess sodium. In acidosis, sodium is retained to combine with the bicarbonate ion and the chloride ion is excreted. This is not the whole story but is the practical side of the mechanism. Should we have a patient who has damaged kidneys and poor concentrating power, we must remember that he needs much more water for urine than the patient with normal kidneys, the reason being that if we allow an insufficient amount of fluid for urine the waste products which should be excreted cannot get out and there is a piling up of urea, nonprotein nitrogen, etc., and a decrease in the carbon dioxide tension. Such a patient will often do very well if a sufficient amount of 5 per cent glucose in distilled water, or plain water by mouth if tolerated, is given.

Of course, if the patient has lost salt through excessive sweating, or by some abnormal means, the chlorides will have to be replaced. It is well to remember that if the patient has anuria due to dehydration all of the 50 per cent glucose, 50 per cent sucrose or concentrated saline will do no good but may cause further damage.

In summary, the majority of patients who have had no abnormal loss of fluid but need intravenous or subcutaneous fluid should get 5 per cent glucose in distilled water preferably intravenously, but it may be given safely under the skin, or I should say as safely as any subcutaneous injection may be given. The routine giving of normal saline solution over a period of days carries with it the danger of producing edema and excessive water retention.

In dehydration with alkalosis or acidosis 5 per cent glucose in normal saline solution, or 5 per cent glucose in Ringer's solution, should be given until the chloride deficiency and dehydration have been corrected.

The basic requirement of the average patient is 3500 cc. of fluid daily. A careful record should be kept of all fluid output and this added to the loss by vaporization. The fluid intake should balance the output and a careful record should be kept of it.

Loss of fluid from the intestinal tract should be replaced volume for volume by normal saline solution. Loss of fluid, when profuse, from wounds and burns should be replaced by normal saline solution and transfusions.

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357 *St. James Building.*

## INJURIES AT OR NEAR THE WRIST

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Injuries at or near the wrist are frequent. The consistent use of the x-ray in injuries about the wrist has demonstrated the presence of many fractures in lesions usually considered sprains, and has revealed a surprisingly large variety of fractures heretofore unknown. Likewise, the so-called Colles' fracture has been shown to be not a simple definite entity, but a deformity produced by a number of different lesions. It would seem, therefore, that the term "Colles' fracture" should either be abandoned or merely used to indicate the type of deformity that often results from these fractures. Classification of fractures near the wrist may be made on the basis of (a) the anatomical lesion, (b) the deformity produced.

### ANATOMICAL LESIONS

1. Fracture of the diaphysis of the radius and ulna close to the epiphyseal line.
2. Fracture of the styloid process of the ulna.
3. Fracture of the styloid process of the radius.
4. Separation of the epiphysis of the radius and ulna.
5. Longitudinal fissure fracture of the radius.
6. Combination of one or more of the above fractures with or without fracture of one or more carpal bones.

### DEFORMITY PRODUCED

1. Fracture with simple swelling about the wrist without deformity.
2. Fracture with Colles' or silver-fork deformity.
3. Fracture with reversed Colles' or Smith's fracture deformity.

It is readily understood that a lower radial

fracture, when simply fissured, may show no deformity but the identical fracture, with displacement, may show a Colles' or reversed Colles' deformity. It will be convenient, therefore, to discuss these fractures grouped according to their deformities.

### ETIOLOGY

Direct violence, such as a blow near the wrist from a heavy falling object, or indirect violence may cause the injury. By far the most common cause is a blow or fall upon the hand, the type of fracture depending upon the position of the hand at the time of the fall, whether flexed or extended, abducted or adducted. Frequent, also, is injury from a kick-back against the hand, of an automobile crank (chauffeur or Ford fracture).

### PATHOLOGY: IN FRACTURES WITHOUT DEFORMITY

The lesions of the radius may be (1) oblique or transverse fracture through or separation of the entire styloid process; (2) an extension fracture or Barton's fracture, a chipping off of the posterior lip of the articular surface of the radius; (3) a flexion fracture or reverse Barton's fracture, a chipping off of the anterior lip of the articular surface of the radius; (4) multiple fracture of the epiphysis, often with longitudinal fissures extending up into the diaphysis; (5) slight epiphyseal separation; and (6) transverse fracture of the diaphysis just proximal to the epiphysis.

The ulna lesions may be: (1) fracture through the tip of the styloid process; (2) fracture through the base of the styloid process; (3) transverse fracture above the epiphysis or epiphyseal separation. All of the fractures may occur singly or a number of them may occur simultaneously.

The Colles' or silver-fork deformity results from an extension fracture, a fall or blow upon the hand in extension in which, as Pilcher has described, there is not only impaction of the carpus against the lower end of the radius, but there may be also splitting off of the lower radial fragments by descent of the upper fragment into it. The impact upon the lower end of the radius results in backward displacement of the lower fragment with, at times, outward displacement and a movement of rotation of the lower fragments in the direction of supination. There is usually

a transverse fracture of the radius just above the epiphysis within two or three cm. of the wrist joint, with or without comminution or impaction of the fragments. There may be radiating or longitudinal fractures of the epiphysis or of the radial shaft.

Associated with any of the above fractures, there may be fracture of the base or tip of the styloid process of the ulna, separation of the ulna epiphysis, laceration of the triangular interarticular cartilage and internal lateral ligament of the ulna, fracture of the scaphoid or semilunar, and dislocation of the os-magnum.

#### DIAGNOSIS

Fractures without displacements will show swelling of the wrist extending up the forearm, and localized pain; movement of the wrist may be limited and painful. Localized tenderness on palpation over the lower end of the radius and ulna is the most definite evidence. These fractures resemble sprains and cannot be differentiated from them in many cases without the x-ray. The diagnosis of fractures with Colles' deformity can usually be made at a glance. The dislocation above the wrist joint and the silver-fork appearance are characteristic. On the other hand, the actual lesion is a difficult matter to determine without a roentgenogram. All supposed sprains, therefore, should be subjected to roentgenography lest these fractures be overlooked.

The reverse Colles' or Smith deformity, results from a flexion fracture. It is comparatively rare. Cases have been described by Barton, Roberts, Pilcher and Smith. The radius is fractured at or near the epiphysis; the lower fragment is displaced anteriorly toward the palmar surface and the upper fragment and the end of the radius, dorsally, increasing the normal radial curve of the flexor surface. With this fracture there may also be fracture or dislocation of one or more carpal bones.

#### TREATMENT

In all severe injuries of the wrist, anteroposterior and lateral roentgenograms should be taken to determine the exact location and displacement of these fractures. However, in simple or so-called "sprains" of the wrist, by close inspection and palpation we can often get good results without subjecting our patients to the extra expense of roentgenography. In fact, many times it has not been

or will not be convenient to have a roentgenogram made.

A correct diagnosis having been made, reduction should be accomplished as soon after the injury as possible. Complete reduction cannot usually be made satisfactorily without the administration of an anesthetic, either local or general. A number of times I have used a local anesthetic with gratifying results to both my patient and myself, by injecting from ten to twenty cc. of a one per cent novocain solution into the hematoma at the site of fracture. After the anesthetic has been administered, the next procedure is to reduce the fracture and immobilize it until union has taken place.

In reducing a Colles' or impacted fracture, it is sometimes necessary to use great force to accomplish a satisfactory reduction. Often it is from the use of too little force that a slight bony deformity remains after union has taken place. However, in the majority of cases, slight traction, hyperextension, traction and hyperflexion with a slight turn of the wrist, and abduction will force the radius into alignment. It requires knack rather than strength. The most important step in the treatment of Colles' fracture is breaking up the impaction and then the accomplishment of reduction. Too much emphasis cannot be laid on this statement. The surgeon should grasp the patient's hand as though he were shaking hands with him, the right hand with the right and the left hand with the left, grasping the lower end of the upper fragments,—that is, the forearm and wrist—with the other hand. The next thing to do is to break up the impaction. The surgeon should not be satisfied until he has actually recreated the fracture, and can elicit the sensation of crepitus.

The next step is the reduction of the fracture. This is accomplished by traction on the hand while pressure with the thumb is made upon the dorsum of the wrist and the index finger makes pressure upon the palmar aspect of the wrist; then with hyperextension, traction, hyperflexion and abduction. When reduction is complete the hand should be allowed to rest naturally without support to determine whether there is a recurrence of the deformity. If there is none, the fracture is properly reduced and may be fixed.

I would like to diverge at this point to say that if I should offer an explanation for ad-



dressings you, as some of you may say, "on such a simple every-day subject," it would be that my purpose is to outline to you what I consider the best and simplest treatment for this condition. You will find very little, if any, description of this treatment in any textbook on fractures. This treatment I learned many years ago from a noted surgeon of the "old school," Doctor Bodine of New York City. I have been using this technique for the past thirty-odd years with gratifying results. It is as follows:

Having diagnosed and reduced the fracture, it is now ready to be immobilized. If you will refresh your minds with the anatomy of the forearm, you will recall that the posterior or extensor surface of the radius and ulna is almost on a straight line from elbow to wrist, and a fixation splint placed on this surface will not only be comfortable, but will hold the fracture in position. Therefore, take a board splint about one-eighth of an inch thick, making it the width of the forearm from elbow to finger tips, having it slightly wider at the wrist so that you do not make undue pressure at this point; pad this splint well with cotton batting and apply a roller bandage on it to maintain a smooth surface. This board splint having been measured, cut and padded before reducing the fracture, you only have to put a light cotton padding around the arm from elbow to metacarpophalangeal articulation, over which you apply a light roller bandage. Then have a triangular cotton or gauze pad ready to apply to the dorsal aspect of the hand and apply a snug roller bandage over all, always paying special attention that you do not apply your bandage too tightly and obstruct the circulation. Also, be sure that you have the injured hand in the position of abduction, which is done by your triangular padding placed on the dorsal surface of the hand and the manner in which you apply your roller bandage, pulling the hand to the ulna side of the arm. Having applied the dressing, as above outlined, you have the fingers on the injured side free, and I always instruct my patient to use them freely and so continue throughout the treatment.

In healthy young adults I usually remove the splint at the end of about two weeks, massage the hand and arm, and reapply splint for another two weeks, when I usually remove

the splint and apply a simple roller bandage about the wrist only, or have the patient get a wide athletic wrist support which he wears during the day, removing it at night. He is instructed to massage the hand, wrist and arm thoroughly, applying the support the next morning, and to continue this for about two weeks when all treatment may be discontinued.

In conclusion, I will say that if I have dropped one thought that may prove of benefit to you in treating this very common, and many times deforming and crippling, injury. I shall feel amply repaid for my efforts in presenting this subject for your consideration.

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*Box 430.*

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## COOPERATIVE MANAGEMENT OF ALLERGIC RHINITIS

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Miami Beach

In recent years enthusiastic reports by allergists conveyed the impression that allergic rhinitis is no longer a baffling problem. Rhinologists will take exception to such unwarranted enthusiasm. Twenty years' experience in combating nasal allergic disease has taught me that we are still groping in the dark, and while progress has been made, our therapy is still largely empiric. Although specific immunization is theoretically logical and probably the ideal, in practice the results have not met expectations.

While from a scientific point of view every patient with vasomotor rhinitis should have a systematic allergic investigation, the proportion in which such a study will yield negative results is high.<sup>1</sup> Most writers agree that in those cases in which an allergic cause cannot be determined, it will be necessary to resort to other forms of treatment. Conservative allergists recognize the fact that in allergic therapy we do not possess a panacea for all types of vasomotor nasal conditions.

### ETIOLOGIC ASPECTS

The causative factors of allergic rhinitis are so varied that no specialty can claim the condition for its own exclusive domain. The more one considers the numerous theories that have been advanced, the more the etiology becomes confusing. There is no question regard-

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<sup>1</sup>Read before the Annual Meeting of the Florida Internists' Society, held at Daytona Beach, May 1, 1939.

ing the role played by offending allergens. Even if we do not accept specific immunization therapy as proof that desensitization can be effected, results from preventive measures provide sufficient evidence that there is an extrinsic influence, which usually becomes effective when the nasal membrane is hypersensitive.

Occasional successes with endocrine therapy suggest a causal relationship which should always be seriously considered. Why small doses of thyroid extract relieve the hyperesthetic symptoms in some cases of vasomotor rhinitis cannot always be explained. The large majority of these patients do not show low metabolic rates, even though many of them are on the minus side. It must be stated, however, that the myxedematous relationship pointed out by Novak<sup>2</sup> has more than passing significance, and that some attention must be paid to its potentialities in a certain group of such nasal allergic cases.

One cannot disregard the observation that the majority of women suffer nasal turgescence previous to or during their menstrual periods. Hoesason<sup>3</sup> again calls our attention to this condition, concerning which he states: "In an unlucky few the turgescence may give rise to even more severe symptoms. In some women the nasal congestion may result in an attack of vasomotor rhinorrhea; this is not an allergic reaction, but an exaggeration of a normal physiologic response . . . This type of vasomotor rhinorrhea which occurs in association with the menstrual function might be termed 'oestrogenic rhinorrhea'; but this does not mean to say that an allergic factor is necessarily excluded."

Jarvis<sup>4</sup> called attention to the color changes of the nasal mucous membrane, claiming that they serve as an index to the body chemistry of the patient. The red nasal septum syndrome, according to him, occurs in individuals who have a low tolerance for acid ash producing foods, medicinal acids or excessive output of muscular energy. A pale septum indicates a state of alkalosis. To the latter group belong the patients susceptible to hay fever, asthma, hyperesthetic rhinitis, coryza and bronchial infection. The treatment is based on the principle of dietary balance supplemented by drugs.

Though diet is not the all important etiologic factor in allergic rhinitis, it is of suffi-

cient importance to merit individualized study. It has been found in some instances that patients who are dismissed by the allergist as "negative to all tests," actually have an allergic background.<sup>5</sup> Often the tests are improperly made, little attention being paid to the testing of foods in connection with abnormal conditions in the nose and throat.

An attempt has been made to explain that both vasomotor rhinitis and atrophic rhinitis are extremes approaching the pathologic in a physiologic variation in fluid content of tissues and to reconcile this variation on electrolyte control, especially of sodium.<sup>6</sup> "Therapy with the aim of forcing chemical change in the electrolyte pattern of body fluids on cases of vasomotor and atrophic rhinitis appears to support the view that fluid and sodium balance is the underlying cause for these clinical entities." (Kaplan<sup>6</sup>).

Benson Bloom<sup>7</sup> advances the view that allergy is predominantly a disturbance of electrolyte metabolism associated with some endocrine (possibly adrenal) dysfunction. Striking benefit was obtained from the use of potassium salts in a series of cases of hay fever. These salts are also employed in urticaria, eczema, nasal polyposis, chronic allergic sinusitis and migraine. In chronic asthma potassium chloride is apparently ineffective; the use of potassium iodide, however, in combination with a salt-poor diet, seems helpful but not curative.

#### PROBLEMS IN DIAGNOSIS

While our review of the etiologic factors is incomplete it includes the more prominent current considerations. The diagnostic problem presents greater difficulties. The accuracy of a diagnosis will depend on whether the study is made by the rhinologist, the allergist, the internist, or by two or more specialists in co-operation. The symptomatology in itself is not a criterion for diagnosis. I have had the unfortunate experience of examining the noses of patients who have been unsuccessfully treated with injections for one to nine years only to find extensive local pathologic processes which made it impossible to effect immunization. It is illogical and unscientific to proceed with any therapy until a correct diagnosis has been made. The allergist has no right to attempt immunization until the completion of a careful examination of the nose and the sinuses. Neither has the rhinologist



any scientific authority to apply topical remedies until a systemic check-up has been made by the internist.

The value of allergic testing is not deprecated, especially if it is found that there is a single offender. If, however, the sensitizing agents are multiple, the information is of scientific interest but immediately minimizes the likelihood of favorable effects through immunization.

The diagnosis of allergic rhinitis requires more than an examination of the patient and a consideration of his symptoms. The successful treatment of this condition, as pointed out by Rackemann,<sup>8</sup> depends on the complete understanding of the patient and his particular problem. This author continues: "In the allergic diseases this is especially true because, as Pirquet has described, the symptoms depend on the peculiar capacity of the individual to react toward certain foreign substances. Not only must the physician understand the physiologic changes in the body of his patient, but particularly in the cases of hay fever, asthma, eczema and the other manifestations of allergy he must understand the patient's environment, his contacts with the various foreign substances that it may contain, and his reaction to these contacts. Recent clinical experience has led to the use of certain 'tricks' in history taking in allergic diseases which are of such practical importance that their recognition constitutes a virtual advance in diagnosis and treatment." I cannot here go into greater detail on this subject, since it is somewhat outside our scope. I do, however, want to bring this matter of history taking before you as one of the valuable aids for the diagnosis of allergic rhinitis.

The differentiation of allergic rhinitis from other upper respiratory conditions is at times difficult. It is now well recognized that allergy is the cause of frequent colds and chronic coughs. That these conditions are due to sensitization rather than bacteria, was suggested by Piness and Miller<sup>9</sup> and later confirmed by Clein<sup>10</sup> who carefully reviews the subject and makes a plea for the early recognition of the allergic state in childhood. Clein asserts that frequent colds may be interpreted as perennial or seasonal hay fever, and chronic persistent cough of this particular type as a preasthmatic symptom. "The early recognition of the allergic state in childhood, with proper

diagnosis and adequate treatment, may prove to be the chief factor in the prevention of asthma and other major allergic disasters."

#### THERAPEUTIC CONSIDERATIONS

More could be said on the subject of diagnosis, but I must restrict myself to the subject under discussion. What has been said with regard to etiology and diagnosis is preliminary to a consideration of the cooperative management of allergic rhinitis. Dean<sup>11</sup> emphasized that every patient presenting a boggy mucous membrane should be subjected not only to a complete allergic but also to a dietary, bacteriologic and endocrine investigation. He remarks: "One of the essential things in the treatment of allergic rhinitis is that the patient should be under the care of a rhinologist . . . A second essential in the treatment of allergic rhinitis is a most careful study of the patient."

I have made it a practice in every case of allergic rhinitis to follow this plan. Earlier experience has taught me that local measures may relieve and even cure a small percentage of patients, but in the large majority more than topical remedies will be required. On the other hand, I have learned that frequently local procedures are valuable adjuncts to allergic, endocrine and other forms of therapy. There is no single drug or procedure which can be employed routinely with success. Nor can we scientifically combine measures without adequate laboratory and clinical evidence. Utilization of certain local procedures on an empiric basis, is, in my opinion, justified when failure has resulted from a comprehensive course of indicated treatment. It is in this group of stubborn and resistant cases that I have advocated the use of zinc iontophoresis as a simple, safe and effective means of affording prolonged palliation.<sup>12, 13</sup>

Nearly every specialist is confronted at one time or another with patients suffering from some form of allergy. "Although the various manifestations of allergy frequently coexist in a greater or lesser degree, it is the predominating one which directs the patient to the internist, the gastro-enterologist, the dermatologist, the ophthalmologist, or the otolaryngologist . . . The high incidence of manifestations in the nose and paranasal sinuses necessitates a close correlation with the various other phases of allergy, for nasal allergy always suggests that other accompany-

ing symptoms may also be of an allergic nature. (Hansel.<sup>14</sup>)

The treatment of allergy is a much larger problem than we were first led to believe. The rhinologist is qualified to look after the nose, the allergist after the allergic symptoms, but it is the internist who gives us important data concerning the state of the body as a whole. The allergist cannot successfully treat allergic rhinitis without the cooperation of the rhinologist and the internist. This likewise applies to the rhinologist and the internist. When one seriously considers, as Hansel has pointed out, that careful and scientific management embraces classification of the patient according to the seasonal occurrence of the symptoms and the etiologic factors concerned, the degree of pathologic change in the nose and paranasal sinuses, the presence or absence of infection, the association of other manifestations of allergy, and the influence of secondary factors, then it requires no further argument that failures in the treatment of allergic rhinitis have been due to lack of coordinated effort. If this paper accomplishes no other purpose, let it represent a plea to overcome this deficiency in the future.

I am not so enthusiastic as to assume that even with cooperative effort our results will be perfect. Allergic rhinitis is too complex a condition. In the light of our present knowledge, however, and until that time when investigations will throw more light on the true etiologic background of allergic diseases, we

must accept cooperative management as the most rational approach to the problem.

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## ASSOCIATION MEMBERSHIP

The steady growth of the State Medical Association is evidenced by the increase in its membership. As this Journal goes to press the membership totals 1,330, as compared to 1,293 for the previous year. When your present secretary and managing director took office the total paid membership was only 645.

The strength of the Association as a whole lies largely in the hands of the thirty-four component medical societies. These individual units of the State Association are headed by capable and enthusiastic officers and the entire membership has been working with unusual harmony over a long period of years. As an indication of interest and enthusiasm of the local units, for the past two years the Marion County Medical Society has been the first to report one hundred per cent of its membership paid. This year Dr. R. C. Cumming, secretary of the Marion County Medical Society, reported over long distance phone on December 26 that his society's membership was one hundred per cent paid for 1940 and that a check remitting the membership dues was in the mail. On January 1, Dr. R. B. Spires, secretary of the Walton-Okaloosa County Medical Society, reported that soci-

ety's membership one hundred per cent paid for 1940. This is a concrete illustration of the efficiency and enthusiasm existing in the component county medical societies.

The home office of the state association belongs to its members and will be conducted according to the policies and instructions laid down by its members through their officers. Every member is invited and urged to visit the home office and contribute suggestions and constructive criticism, in order that activities may be directed, as far as possible, according to the wishes of the entire membership.

## 1940 CENSUS WILL BRING VALUABLE VITAL STATISTICS

While the inventors of diabolic instruments of war have been ingeniously practicing their craft, the scientific forces engaged in the preservation of life have made even greater progress. Records of the U. S. Bureau of the Census indicate that depletion of population by deaths on the battlefields is of relatively small account, when balanced against the results of the less publicized but equally dramatic contributions to the prolonging of human lives now being made by medical science.

It is possible, through Census records, to make interesting comparisons, for example, of death rates prevailing around 1900 and those of today. If the 1900 figures still governed, over 450,000 more deaths would occur this year in the United States than actually will take place.

In 1900, for instance, tuberculosis caused 201.9 deaths per 100,000 population. Now it causes but 53.6. Using the 1900 ratio against a present estimated U. S. population of 132,000,000, 188,500 Americans who otherwise would die are *not* dying this year from this cause alone—a cause which in the aggregate has cost more lives than the toll exacted in all the wars of history. This year, the prevention of deaths from tuberculosis will save more than four times as many people as the number of American soldiers killed on all the World War battlefields.

The Division of Vital Statistics in the Census Bureau keeps accurate records on the 15 maladies against which medical science has made its greatest advances. These are tuber-



culosis, typhoid, smallpox, measles, scarlet fever, diphtheria, influenza and pneumonia, erysipelas, malaria, bronchitis, diarrhea and enteritis, cirrhosis of the liver, maternity deaths, congenital malformations and diseases of infancy, and nephritis. For these fifteen, the net reduction of deaths per year per 100,000 people has been 542, which would indicate a saving of 704,600 lives this year as against the 1900 mortality rate.

It is essential that every citizen lend his full cooperation toward making each census a complete one. At least one phase of the 1940 enumerations—the Census of Population—will touch every person in America directly, and many people will be queried on two or even more of the various schedules.

Answers to Census questions are required by law, but the same statute requires the Census Bureau to maintain its long-established policy not to disclose any facts about individual persons or establishments. Individual reports are not available to any other government department. Assurance thus is given that reports to the Bureau will not be used for taxation, regulation, or investigation.

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### THE RECORD REFUTES CHARGES THAT A. M. A. IS REACTIONARY

"While captious critics have been denouncing the American Medical Association as reactionary and obstructive, its members have been conducting numerous and extensive experiments during the last seven years in search of ways of organizing payments for medical service and adjusting the burden of medical cost to the abilities of varying economic classes," *The Journal of the American Medical Association* for Dec. 30 declares.

"Never have so many, so varied or so significant projects been carried out in any other country. When the burden of medical care for the indigent disrupted the systems of county and township doctors, drained the resources of philanthropic organizations and became too heavy for gratuitous service by physicians to bear, the various state and county medical societies developed almost the only successful plans for efficiently distributing such resources as were available to provide medical care for the indigent.

"During the period 1932 to 1938, between

200 and 300 county societies entered into contracts with relief authorities to provide medical service for the indigent. These were organized to include such protection to the interests of the patients and the public as free choice of physician and economical administration of the always insufficient funds. A number of county societies have also experimented with medical service bureaus for the low income classes. Some of these bureaus are still in operation and have been helpful to many persons in this class in enabling them to meet the costs of needed medical care. All these plans and all those which are now in operation are considered frankly as experiments to be expanded, restricted, altered or abolished as they prove their value in protecting the health of those served. If they are not found desirable they may be abandoned. The medical society stands the loss in time and money expended, but no political, financial or occupational vested interests are created and left behind to hamper further experiments."

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### PRESIDENT'S HOSPITAL PROGRAM RECOGNIZES THE A. M. A. PLATFORM

"On December 22 President Franklin D. Roosevelt, in his regular interview with the press, gave definite intimation as to his point of view relative to proposed legislation in the field of health," *The Journal of the American Medical Association* for Dec. 30 states in an editorial. After summarizing the interview the editorial goes on to point out that the reported views of the President are a recognition of some of the objectives of the Association's platform and that the facilities, help and advice of the Association's Board of Trustees and officers are available to the government in working out any sound plan for meeting immediately any health needs which may be demonstrated. The editorial continues:

According to a report from the United Press he said that the administration is considering a program for federal construction of hospitals in areas where such facilities are lacking, and he intimated that the plan might be recommended to the coming Congress. According to the United Press, he said the program, if undertaken, would start modestly but could be enlarged as desired. No estimate of the cost has been completed, but the President emphasized, says the report, that it would cost less than the more extensive health and school programs proposed in bills introduced by Senators Robert F. Wagner, of New York, and Pat Harrison, of Mississippi.

According to the United Press, his comments indicated that he is dissatisfied with both these measures. He said that the Wagner or Harrison bills would cost a lot of money and that the chief trouble was in the requirements for states to match federal funds. The new program he outlined would provide that the government bear 100 per cent of the hospital construction costs, retain title to the institutions and build them only in areas where local interests offered satisfactory assurances that they would operate and maintain the institutions.

Under a matched program, Mr. Roosevelt is said to have pointed out, those states which have the most money could obtain the most federal funds. "They already have the best hospitals and health conditions," he pointed out, says the United Press report, "while the poorer states have a lower health level and insufficient funds to obtain federal money on a matched basis. Since elimination of the PWA 55-45 matched money program, the President said, the federal government could afford to finance in a small way medical centers in those areas needing them. He suggested fifty hospitals as a start. He pointed out as an example one New York county of 100,000 population with six good hospitals and three Southern counties of the same population without any medical facilities. The cost of the program he has envisioned would not be great, but it would mark the first experimental steps to bring health facilities to those areas needing them most, he explained. The major part of the work would be done by the WPA as far as possible, he said. The Public Health Service and a committee of doctors would pass on the plans and determine the ability and willingness of localities to operate and maintain the institutions. The President said he had talked over the plan with a number of doctors and will discuss it soon with the American Medical Association.

"He said doctors from many locales had told him they were unable to raise capital to build hospitals but that if they could get small plants they could maintain and operate them. As outlined by the President, each institution would consist of a one story hospital building of two wings, one each for white and colored persons, and an administration building with clinic, operating room and laboratory. He estimated that each hospital would provide 100 beds at a cost of around \$150,000. The President emphasized that his program is no grandiose scheme for putting up hospital centers costing \$10,000,000 each and he said he did not think the medical association's objections to government health programs would apply to such small hospitals. The President said that Miss Josephine Roche, former Assistant Secretary of the Treasury, was remaining with his Inter-departmental Committee on Health, but he said it did not mean that Security Administrator Paul V. McNutt was being eased out of the health program. He said a story to that effect about McNutt was crazy and made out of whole cloth."

Thus the President has recognized some of the objectives of the platform of the American Medical Association. He has recognized the primary objection inherent in the principal of grants-in-aid. The American Medical Association has approved the development of medical facilities where need can be shown, with provision for local administration and control. It has opposed the grandiose plans of the Wagner bill. The Board of Trustees and the officers of the American Medical Association have repeatedly offered their facilities and help and advice to the government in working out any sound plan for meeting immediately any needs which may be demonstrated.

### WARNING OF IMPOSTORS

At this time of the year there are always a number of undesirable transients in the state and almost every winter doctors are swindled through patronizing unknown agents.

Last January at least two of our members suffered the loss of surgical instruments which a well appearing and plausible salesman, working under the name of Morrison as a representative of the Morrison Co. (apparently nonexistent), purported to take up for the purpose of replating and repairing. Nothing further was ever heard of him.

For their own protection our members should refuse to pay a deposit to an unknown salesman or entrust him with any article of value without first making an investigation. The Association will be glad to cooperate in securing information regarding unknown characters who work among the doctors.

### INTERNATIONAL COLLEGE OF SURGEONS

The United States Chapter of the International College of Surgeons (Geneva) announces its Fifth Assembly Conference, February 12-14, 1940, at the Florida Medical Center, Venice, Florida. The following distinguished speakers will appear on the scientific program:

- DR. MOSES BEHREND, Philadelphia, Pa.  
*"The Role of Extrapleural Pneumothorax in the Treatment of Pulmonary Tuberculosis."*
- DR. WM. J. CARSON, Milwaukee, Wisconsin.  
*"Retroperitoneal Lipoma."*
- DR. WARREN B. DAVIS, Philadelphia, Pa.
- DR. TEMPLE FAY, Philadelphia, Pa.  
*"Refrigeration in Human Beings and Its Effect on Undifferentiated Cells Particularly Related to Cancer, a New and Important Subject."*
- DR. ALBERTO INCLAN, Havana, Cuba.  
*"Surgical Treatment of Giant Cell Tumors of Bones."*
- DR. CHEVALIER JACKSON, Philadelphia, Pa.
- DR. WM. R. LOVELACE, Albuquerque, New Mexico.
- DR. WILLIAM E. LOWER, Cleveland, Ohio.  
*"The Indications for and the Result of Ureteral Transplantation into the Recto-Sigmoid."*
- DR. MANUEL A. MANZANILLA, Mexico City, Mexico.  
*"Vaterian Pseudodiverticulum of the Duodenum."*
- DR. RUDOLPH NISSEN, Istanbul, Turkey.  
*"Reconstruction of the Ureter."*
- DR. BRADLEY M. PATTEN, Ann Arbor, Michigan.
- DR. LEWIS F. SMEAD, Toledo, Ohio.  
*"Management of Acute Hemorrhagic Pancreatitis."*
- DR. CARL STEINKE, Akron, Ohio.  
*"Treatment of Complications of Penetrating Wounds of the Thorax and Associated Injuries."*
- DR. THEW WRIGHT, Buffalo, New York.
- DR. HUGH YOUNG, Baltimore, Md.

All members of the Association are invited to attend all of the scientific sessions. For further information, communicate with Dr. Julien C. Pate, 1101 First National Bank Building, Tampa.



## MEDICAL LICENSES GRANTED

Dr. W. M. Rowlett, secretary of the State Board of Medical Examiners, reports that of thirty-two applicants who took the State Board of Medical Examiners' examination in Jacksonville on November 13 and 14, twenty-nine were successful and have been issued licenses to practice medicine and surgery in Florida. The names and addresses of the successful applicants are as follows:

Walter O. Allen; Hendersonville, N. C. (S. C., 1926).  
Phillip M. Bichard; Episcopal Eye, Ear and Throat Hospital, Washington, D. C. (Louisiana, 1935).  
Jackson L. Bostwick; St. Luke's Hospital, Jacksonville (Tulane, 1939).  
Lee E. Bransford, Jr.; Duval County Hospital, Jacksonville (Temple, 1939).  
Glenn W. Bryant; Grady Hospital, Atlanta, Ga. (Louisville, 1938).  
Joseph M. Caputo; 27 Division Street, Lake City (Marquette, 1935).  
Thomas S. Carter; Riverside Hospital, Miami (Vanderbilt, 1932).  
Frank N. Cooke; 307 Cottage Avenue, Jacksonville (Temple, 1939).  
Hilbert N. Dricken; 607 North 23rd Street, Milwaukee, Wis. (Marquette, 1935).  
Donald H. Gahagen; Windber Hospital, Windber, Pa. (Temple, 1939).  
A. Judson Graves; University of Pennsylvania Hospital (X-Ray Department), Philadelphia, Pa. (Georgia, 1933).  
George D. Hoffeld; 156 Third Street, Troy, N. Y. (Long Island, 1931).  
Leo Honigsberg; 845 Collins Avenue, Miami Beach (New York, 1928).  
Emil M. Isberg; 1552 Euclid Avenue, Miami Beach (Michigan, 1938).  
O. L. Kelley; Emory University Hospital, Emory University, Georgia (Emory, 1939).  
John M. Kibler; 430 Fifth Street, South, Rochester, Minn. (Johns Hopkins, 1935).  
Charles Lippow; 201 Eastern Parkway, Brooklyn, N. Y. (Bern, 1917).  
John W. Meredith; Scottsville, Ky. (Chicago, 1933).  
H. Gerald Morin; Mound Park Hospital, St. Petersburg (Rochester, 1938).  
John W. Pender; Carthage, Miss. (Tulane, 1935).  
Richard Reeser, Jr.; 525 Third Street, S. W., Rochester, Minn. (Cornell, 1935).  
Max Resnicoff; 141 Joralemon Street, Brooklyn, N. Y. (New York, 1917).  
Ralph S. Sappenfield; 111 East 26th Street, New York, N. Y. (Indiana, 1930).  
Randolph Shevach; care Kings County Hospital, Brooklyn, N. Y. (Long Island, 1936).  
Maurice A. Shinefeld; 4601 Post Avenue, Miami Beach (Rush, 1937).  
Charles W. Smith; 1108 Colquitt Avenue, N. E., Atlanta, Ga. (Emory, 1937).  
William J. Sweeley; Opa-Locka (Rush, 1932).  
Ellsworth F. Waite; Box 57, Worcester, Mass. (Boston, 1936).  
Leo A. Zuckerman; 365 Broadway, Saratoga, N. Y. (Albany, 1936).

Dr. Rowlett also reports that forty doctors of medicine took the first Basic Science Board examination, held in Gainesville on November 4. There were five failures before the Basic Science Board.

## CORRESPONDENCE

### MEDICAL WRITING SERVICE

*To the Editor:*

As an editor of wide experience dealing constantly with editorial problems, you may be interested in letting the readers of *The Journal* know of the medical writing service I am prepared to offer the members of the Florida Medical Association. This service is designed to assist the physician who writes in the way that will be most helpful to him.

The volume of material submitted for publication today indicates on the part of the profession a growing awareness of the importance of medical writing in the making of a successful physician. The presentation of papers before societies brings him and his work to the attention of hundreds; through their publication he becomes known to thousands. Also, the more he writes, the better he himself becomes informed on the subjects he discusses.

Along with the editor, the experienced medical essayist knows that a well prepared paper on a practical, timely subject, that is of interest to a reasonable number of readers, is always acceptable for publication. No subject is overworked so long as new, scientific evidence pertaining to it is forthcoming. The paper that contains new thought, original observation or record of experience is sure to be favorably received.

It happens, however, that many articles cumber the literature today which neither elevate its tone nor add to the knowledge of scientific medicine. Too frequently an author, often responding to the demand of a medical society for a contribution to its program, selects his subject haphazardly and writes indifferently from a sense of duty. His paper, even when based only on textbooks and easily accessible literature, serves a useful purpose as a basis for a general discussion in the society before which he presents it, and he is perhaps warmly congratulated by its members. Once such a paper is resolved into cold type, however, without the personality and inflections of the author to embellish it, the reader's eye readily perceives the faults that the listener's ear failed to detect.

As a careful editor you are well aware that a surprising number of papers are rejected because they are written for reading, not for printing. Some are ungrammatical, verbose, discursive, poorly organized and without sequence in argument or arrangement of subject. Others lack brevity and conciseness; they are rambling and weighted with unnecessary details. They may contain colloquial language and personal allusions as well as material that is unrelated and irrelevant. It has been well said that a manuscript that is fit to read is sometimes fit to print, but a manuscript that is fit to print is always fit to read.

The service offered enables the medical essayist to have the literature on whatever subject he chooses reviewed and summarized or abstracted. Once he has written a paper, whether in rough draft or more finished style, he may have it edited and typed in proper form for publication; or assistance will be given in the initial drafting of the article. He may have prepared for publication the report of a case that he desires to place on record. If interested in a medicolegal problem, he may procure a resume of the medicolegal aspects of the subject in question. Also, he may obtain aid in the preparation of an informal talk or public address. The fees for these services are reasonable.

It is the aim of this service to save the medical author both time and effort by giving assistance in whatever form he finds most useful. At the same time, it would insure for him a paper not only suitable for reading but also acceptable to the most discriminating editor. I trust the members of the Association will be interested in this type of service.

Very truly yours,  
EDITH B. HILL

935 South Oregon Avenue, Tampa.

## BIRTHS

Dr. and Mrs. P. H. Guinand of Clearwater announce the birth of a daughter, Mary Matile, on December 14, 1939, at Morton Plant Hospital.

## STATE NEWS ITEMS

Dr. Walter C. Jones of Miami was elected to Fellowship and Dr. Gerry R. Holden of Jacksonville was advanced to Senior Fellowship in the Southern Surgical Association at its meeting held in Augusta, Ga., December 5 to 7, 1939.

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On December 4, 5 and 6 an institute on tuberculosis was held at the State Tuberculosis Sanatorium at Orlando, especially for county health officers. Eighteen counties were represented. Discussions were lead by Dr. R. D. Thompson, superintendent and medical director of the State Tuberculosis Sanatorium; Dr. A. B. McCreary, State health officer; Dr. J. A. Kelk, Dr. L. H. Kingsbury and Dr. W. O. Fowler.

\* \* \*

The Radiological Society of North America met in Atlanta, December 11-15. Dr. O. O. Feaster of St. Petersburg is chairman of the Executive Committee for the ensuing year; Dr. J. C. Dickinson of Tampa was reappointed a member of the Legislative Committee; Dr. Frazier J. Payton of Miami Beach was reappointed councilor for Florida; and Dr. F. K. Herpel of West Palm Beach served as a member of the nominating committee.

Florida doctors who attended: F. J. Mantell, Bay Pines; J. Maxey Dell, Jr., Gainesville; John A. Beals, Thomas H. Lipscomb, Jacksonville; John J. Jares, Lakeland; Frazier J. Payton, Miami Beach; John N. Moore, Ocala; J. A. Pines, Walter A. Weed, Orlando; Annette Feaster, O. O. Feaster, J. A. Herring, St. Petersburg; H. O. Brown, J. C. Dickinson, Charles M. Gray, Tampa; F. K. Herpel, West Palm Beach.

\* \* \*

Dr. A. B. McCreary of Jacksonville was elected president of the Florida Public Health Association at its eleventh annual meeting held in Jacksonville in December. The State Medical Association is honored to have one of its members thus recognized.

The annual meeting of the Suwannee River Medical Society was held in Live Oak Thursday, December 14. The guest speaker of the evening was Dr. J. Ralston Wells of Daytona Beach, whose subject was "Severe Toxic Thyroid." The newly elected officers for 1940 are Dr. Thomas H. Bates, Lake City, president; Dr. Harry S. Howell, Lake City, secretary-treasurer. The next meeting will be held in Lake City.

## C. E. TUMLIN

The death of Dr. C. E. Tumlin, long a member of the State Board of Medical Examiners, was deplored by that body in the following Resolutions which were recently adopted:

WHEREAS, the Florida State Board of Medical Examiners has suffered a loss in the sudden and untimely death of Dr. C. E. Tumlin, a most valuable, stalwart, respected and beloved member, and

WHEREAS, Dr. Tumlin was a faithful and efficient member of the Board, serving since September 24, 1930, and having held the offices of vice-president and president.

He gave cheerfully of his time and talent to every cause intended to strengthen and benefit the Board, having always been a true disciple of the principles of organized medicine, always maintaining the highest standard of ethical relationship.

RESOLVED, That in the death of Dr. Tumlin the Board has lost a member whose place will be hard to fill, whose active interest will be sadly missed, whose devotion to its best interests has been largely responsible for its development and influence in the establishment of the present high standard of medical licensure in Florida.

RESOLVED, That we deplore the loss of Dr. Tumlin and feel the loss of this member very deeply, that each member of the Board is grieved, and extend to his family our deepest sympathy.

BE IT FURTHER RESOLVED, That the State Board of Medical Examiners of Florida offers condolence to the bereaved family in this hour of sadness over their departed member and that a copy of these resolutions be sent to his bereaved widow and family and the State Medical Journal.

B. A. Chapman,  
Thomas W. Hutson,  
Carl Williams,  
Committee.



## COMPONENT COUNTY SOCIETIES

### BAY COUNTY MEDICAL SOCIETY

At the meeting of the Bay County Medical Society held December 14, the following officers for 1940 were elected: President, A. H. Lisenby; vice president, W. E. Middlebrooks; secretary-treasurer, W. C. Roberts. Doctor Roberts was elected delegate to the convention in Tampa for 1940 and Dr. J. M. Nixon elected alternate delegate.

Dr. M. F. Parker from Greenville, Alabama, has recently become a member of the Lisenby Hospital Staff, with offices in the hospital, and associated with Dr. A. H. Lisenby. He will engage in general practice. Doctor Parker was admitted to the membership of Bay County Medical Society for 1940.

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### DADE COUNTY MEDICAL SOCIETY

At the December meeting of the Dade County Medical Society, the following officers were elected to serve for 1940: President, Joseph S. Stewart, Miami; vice president, Wiley Sams, Miami; secretary, Franz Stewart, Miami; treasurer, W. L. Fitzgerald, Miami.

\* \* \*

### DE SOTO-HARDEE-HIGHLANDS-CHARLOTTE-GLADES COUNTY MEDICAL SOCIETY

The members of the DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society held their December meeting at the Hotel Simmons, Wauchula. Following a sumptuous turkey dinner, a round table discussion was held.

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### DUVAL COUNTY MEDICAL SOCIETY

Dr. Charles B. Mabry was installed as president of the Duval County Medical Society at a meeting held on December 5, and Dr. S. R. Norris was designated as president-elect. Other officers who were named were: vice president, James M. Bryant; secretary, Lauren M. Sompayrac; and treasurer, Alan Brown.

\* \* \*

### ESCAMBIA COUNTY MEDICAL SOCIETY

At the meeting of the Escambia County Medical Society held at the Pensacola Hospital, December 12, the following officers were

elected: President, Sidney G. Kennedy, Pensacola; vice president, W. P. Hixon, Pensacola; secretary-treasurer, W. E. Tugwell, Pensacola; delegates, H. L. Bryans and C. C. Webb; alternates, L. C. Fisher, Jr., and J. N. McLane.

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### HILLSBOROUGH COUNTY MEDICAL SOCIETY

At the election of officers held by the Hillsborough County Medical Society on the evening of December 5, the following were chosen to guide the destiny of the society for the coming year: President, John R. Boling, Tampa; vice president, J. C. Pate, Tampa; secretary-treasurer, James S. Grable, Tampa. The delegates who will represent the society at the next meeting of the State Association are: W. M. Rowlett, R. S. Torbett, H. Mason Smith, J. W. Alsobrook, and T. C. Maguire.

\* \* \*

### LAKE COUNTY MEDICAL SOCIETY

The annual meeting of the Lake County Medical Society was held at the Medical Center, Eustis, on the evening of December 7. Officers were elected as follows: President, W. L. Ashton, Umatilla; vice president, Marion B. O'Kelley, Leesburg; secretary-treasurer, G. Oliver Emerson, Tavares.

\* \* \*

### MARION COUNTY MEDICAL SOCIETY

Again the Marion County Medical Society captures the honor of being the first society in the state to report 100% dues paid. A check covering 1940 dues for the entire membership of this society was received by the State Association the latter part of December. We believe this establishes an all-time record for promptness in the complete payment of dues by any society. Congratulations, Marion County Medical Society!

\* \* \*

### PALM BEACH COUNTY MEDICAL SOCIETY

The regular meeting of the Palm Beach County Medical Society was held on November 27, at the Tusawilla Club, inaugurating a new idea of combined dinner and business meeting. After the business session, a symposium

sium on Diabetes was held with papers read by the following doctors:

1. Presentation of Case—T. Z. Stanley.
2. Preoperative and Postoperative Treatment of the Surgical Diabetic—W. W. George.
3. Diabetes Simulating the Acute "Surgical" Abdomen—V. D. Stone.
4. Amputation in Diabetes—S. W. Fleming.
5. Mechanism of Acidosis in Diabetes—V. M. Johnson.

The attendance was 77.58%.

The December meeting of the society was held on the 18th at the George Washington Hotel, West Palm Beach. Election of officers was held which resulted as follows: President, James H. Pittman, West Palm Beach; vice president, W. O. Arnold, West Palm Beach; secretary, C. J. Derrick, West Palm Beach; treasurer, F. K. Herpel, West Palm Beach; delegates, L. J. Netto, F. K. Herpel, and James H. Pittman; alternates, S. W. Fleming, W. W. George, and W. E. VanLandingham.

\* \* \*

#### PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Dr. W. H. Walters entertained the Pasco-Hernando-Citrus County Medical Society at the hotel in Lacoochee, Thursday evening, December 14. A quail dinner was served by the host and enjoyed very much by all those present.

The following officers were duly nominated and elected: Dr. W. H. Walters, Lacoochee, president; Dr. W. B. Moon, Crystal River, 1st vice president; Dr. S. C. Harvard, Brooks-

ville, 2nd vice president; and Dr. G. R. Creekmore, Brooksville, re-elected secretary-treasurer. Dr. W. H. Walters was elected delegate to the State Medical Association meeting with Dr. Claude L. Carter as alternate delegate.

Dr. James L. Estes of Tampa, the invited guest, gave a very interesting report on abscesses.

Those present were: Drs. Claude L. Carter, G. R. Creekmore, Edw. H. Brown, Geo. A. Dame, S. C. Harvard, W. W. Jones, W. H. Walters, and James L. Estes.

\* \* \*

#### PINELLAS COUNTY MEDICAL SOCIETY

The Pinellas County Medical Society held a dinner meeting at the Clearwater Yacht Club, Clearwater, on the evening of December 1. Dr. M. A. Nickle read an interesting paper on "Vertigo" and Dr. John Shahan presented several case reports, illustrating his talk with x-ray plates.

\* \* \*

#### POLK COUNTY MEDICAL SOCIETY

The December meeting of the Polk County Medical Society was held at Bartow on the evening of the 13th. The following officers were elected to serve during 1940: President, Henry Fuller, Mulberry; vice president, W. F. Peacock, Bartow; secretary-treasurer, J. W. Annis, Lakeland; delegates, Herman Watson, R. L. Cline, J. R. Boulware, Jr.

Dr. C. H. Murphy presented a paper on "The Thymus Gland" as a feature of the scientific program.

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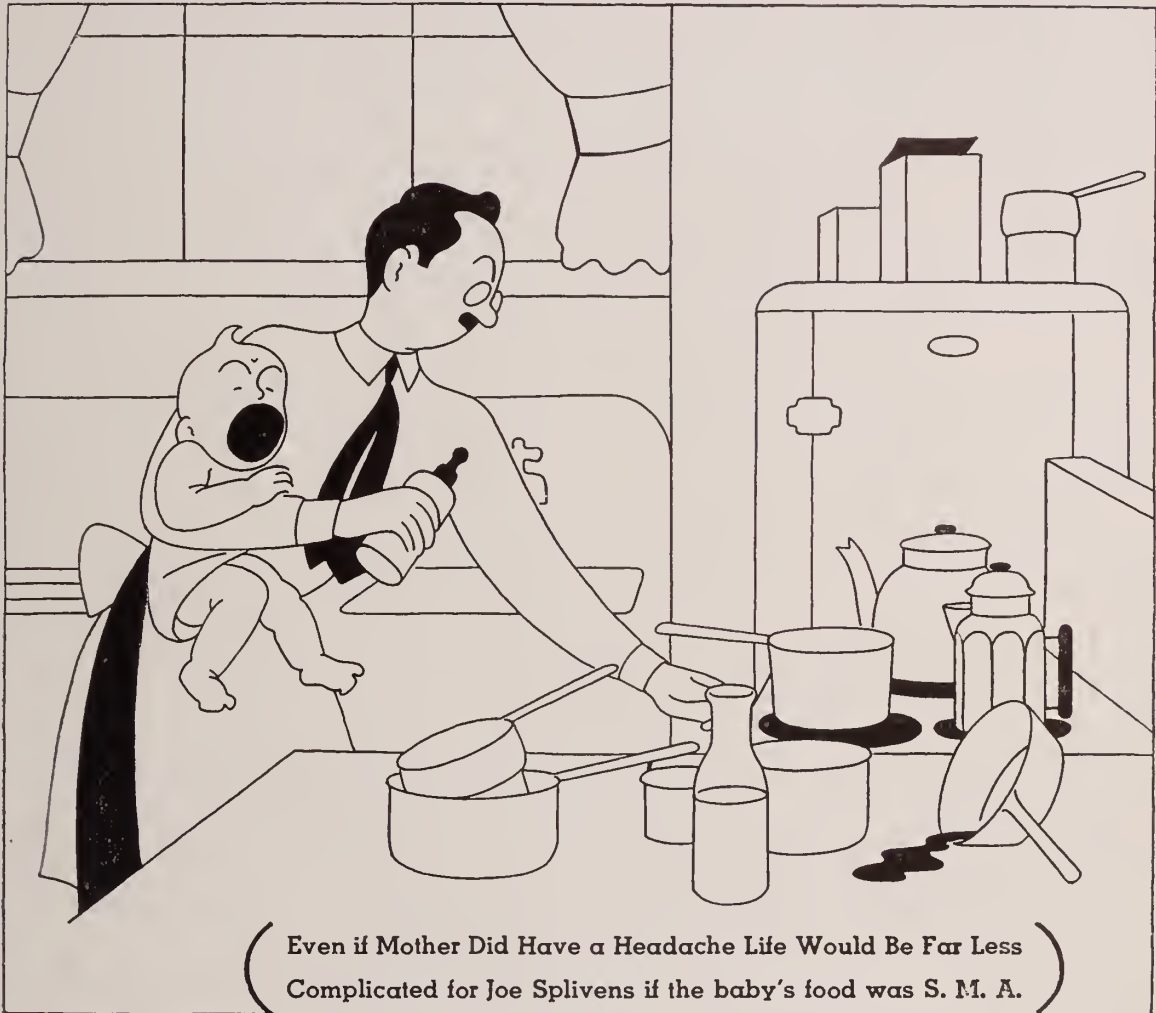
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SARASOTA AND MANATEE COUNTY MEDICAL  
SOCIETIES

A joint meeting of the Sarasota and Manatee County Medical Societies was held November 21 at the Whitfield Estates, Sarasota. Dr. W. E. Wentzel of Bradenton and Dr. Robert T. Nelson of Tampa were featured speakers. Doctor Wentzel reported on a recent survey of hookworm in the Manatee County schools and Doctor Nelson presented a paper on "The Management of Difficult Obstetrical Cases."

\* \* \*

## SEMINOLE COUNTY MEDICAL SOCIETY

Dr. Wade H. Garner was elected president; Dr. G. S. Selman, vice president; and Dr. Douglas G. Scott, secretary-treasurer at the annual election held in connection with the December meeting of the Seminole County Medical Society.

As a feature of the scientific program, Dr. E. E. Hitchcock of Orlando presented an interesting paper on "Diarrheas in Infants and Children."

\* \* \*

## VOLUSIA COUNTY MEDICAL SOCIETY

The election of officers was held by the Volusia County Medical Society at a meeting on December 12 at the Halifax Hospital, Daytona Beach. Those elected were: President, L. V. L. Brown, DeLand; vice president, J. R. Chandler, Daytona Beach; secretary-treasurer, R. L. Miller, Daytona Beach.

A general discussion of the proposed Volusia County Health Unit was held and a committee of five doctors appointed to work out further details of the management of such a unit. Serving on this committee are Drs. J. Ralston Wells, L. W. Glatzau, Ludo von Meysenbug, Hugh West, and W. C. Chowning.

\* \* \*

WALTON-OKALOOSA COUNTY MEDICAL  
SOCIETY

The second society on the honor roll of 100% paid societies is the Walton-Okaloosa County Medical Society whose check for 1940 dues covering the entire membership was received at the State Association office on January 2. Congratulations!

The society is headed this year by Dr. A. G. Williams of Lakewood, president, and Dr. R. B. Spires of DeFuniak Springs, secretary-treasurer.

## ABSTRACT DEPARTMENT

*Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.*

**The Minimum Incidence of Intestinal Protozoa in a Representative Sampling of the Adult Population in Florida, BORLAND, JAMES L., Jacksonville, South. M. J. 32: 364-370 (Apr.), 1939.**

The minimum protozoal incidence in Florida was found to be 22 per cent. The incidence of *Endamoeba histolytica* was found to be 6 per cent, *Endamoeba coli* 9 per cent, *Endolimax nana* 7.4 per cent, *Giardia intestinalis* 5.6 per cent, all others in small amounts. These figures are high enough to make protozoal infections important in diagnosis, though no more in Florida than elsewhere, as these figures compare favorably with those in other parts of the country.

The technic of collection of specimens in order to find these parasites is of paramount importance, as is also the method of examination of stools. It is emphasized that a single negative examination on a suspected case of amebiasis is worthless, and that at least six defecated specimens should be examined, these six to include one after a purge, and one the day after a purge; also one specimen should be obtained by sigmoid lavage.

The incidence of protozoal infections is higher in those in the higher income levels, and higher in persons who have been to the tropics.

The author emphasizes that *Endamoeba histolytica* was never found in patients in whom no inflammation of the large intestine could be demonstrated, and he makes a plea for a wider appreciation of the possibility of protozoal diseases in some of the obscure and unimproved gastro-intestinal disorders, or even in the absence of any intestinal symptoms.





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SYPHILIS, GON-  
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NEREAL DISEASES,  
Vol. 23, No. 2,  
pages 201-206,  
March, 1939.

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*My Dear Auxiliary Friends:*

Time flies all too swiftly!

As your President let me extend delayed Greetings: "With every good wish for the New Year."

On Wednesday night, December 13, I had the pleasure of visiting the Polk County Medical Auxiliary at a dinner meeting held in the New Oaks Hotel, Bartow. This Auxiliary has a well rounded out program and is a splendid organization. The Student Loan Fund, to be sponsored by the State Auxiliary was heartily endorsed as an excellent project.

This Auxiliary has a unique way of raising funds which you will hear about at our Annual Meeting to be held in Tampa.

And, may I bring to your attention, "Medicine in the News," timely topics from the American Medical Association, and the National Broadcasting Company, every Thursday, 4:30 p. m. (E. S. T.) Blue Network—coast to coast. This series of thirty weekly broadcasts which opened November 2, 1939, feature "Facts, drama, entertainment, music." These announcements are on blotters, which may be secured free by writing to the American Medical Association, Chicago, Illinois. Please give these talks publicity in your Auxiliaries. And, may I add, now after the Christmas rush is over is a good time to put on that Health Program in your Woman's Club.

Dr. Spencer Folsom and Dr. Gilbert Osincup were our guest speakers in a Health Program put on in Orlando at the Sorosis, which

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was sponsored by the Orange County Woman's Auxiliary. This program went over big. The club has asked for another next year.

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Sincerely,

Carolyn F. Ingram

\* \* \*

The Auxiliary to the Pinellas County Medical Society held its first meeting of the year on Tuesday, November 21 at 12:30 o'clock. This was a social meeting which was held at the Carleve Hotel with about thirty members present. The long luncheon table was decorated with bronze, yellow, and white chrysanthemums. The president, Mrs. C. O. Anderson, introduced the committee in charge of the luncheon and also special guests. She announced that no business would be taken up at the monthly meetings, but would be attended to at the regular meetings of the executive board. Mrs. Anderson reminded the group of the December meeting which was scheduled as a dinner dance with the husbands as guests. Following the luncheon, bridge was played by all those desiring to remain. The luncheon and afternoon seemed to be thoroughly enjoyed by all those present.

Mrs. O. N. Nelson.

\* \* \*

The many friends of Mrs. Curtis Holt Sory of Ft. Lauderdale will be saddened to learn of her death on December 6, following a brief illness.

\* \* \*

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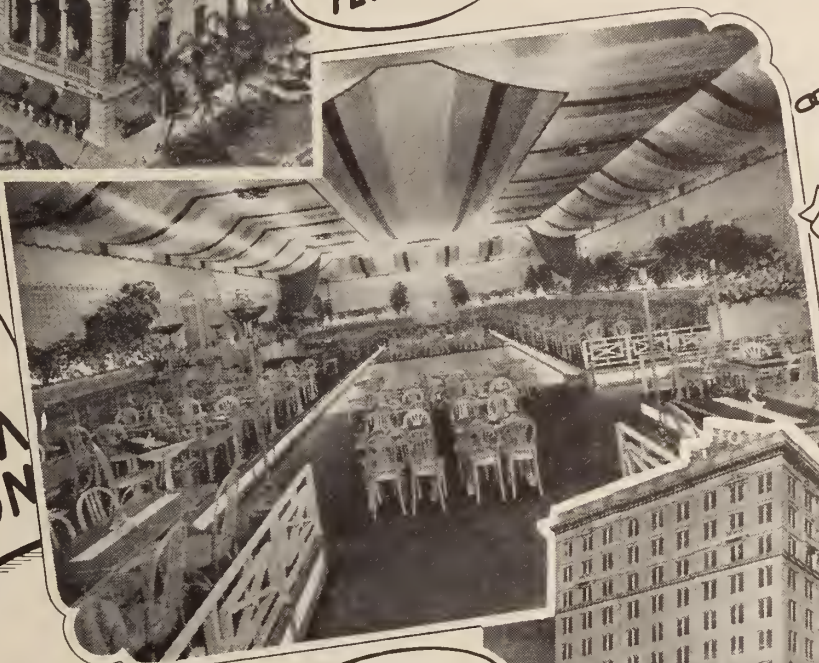




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ACCEPTED FOODS, AND THEIR NUTRITIONAL SIGNIFICANCE, a publication of the Council on Foods of the American Medical Association. This volume contains descriptions and detailed information regarding the chemical composition of more than 3,800 accepted products, together with a discussion of the nutritional significance of each class of foods. The book provides also the Council's opinion on many topics in nutrition, dietetics and the proper advertising of foods.

This book will be a welcome reference book for all persons interested in securing authoritative information about foods, especially the processed and fabricated foods which are widely advertised. The accepted products are classified in various categories; fats and oils; fruit juices, including tomato juice; canned and dried fruit products; grain products; preparations used in the feeding of infants; meats; fish and sea foods; milk and milk products other than butter; foods for special dietetic purposes; sugars and syrups; vegetables and mushrooms; and unclassified and miscellaneous foods, including gelatine, iodized salt, coffee, tea, chocolate, cocoa, chocolate flavored beverage bases, flavoring extracts, dessert products, baking powder, cream of tartar, baking soda, cottonseed flour. There is a suitable subject index as well as an index of all the manufacturers and distributors of food products that stand accepted by the Council on Foods.

*Accepted Foods* is indispensable for the library of every physician concerned with foods and nutrition.

Cloth, price \$2.00 postpaid. Pp. 512; Chicago: American Medical Association, 1939.

\* \* \*

ROCKEFELLER FOUNDATION: INTERNATIONAL HEALTH DIVISION. ANNUAL REPORT, 1938. Each year the International Health Division of The Rockefeller Foundation publishes a separate account of its activities, intended for readers with a specialized interest in the field of public health. The program of this Division falls into three parts, the first of which concerns the control of specific diseases, such as yellow fever, influenza, malaria, and tuberculosis. The second deals with aid to departments of health, either central or local in character, engaged in health demonstrations or the initiation of permanent new lines of public health activity. Finally, the International Health Division is interested in public health education, in which support is given to selected schools and training centers, as well as to a program providing fellowships for postgraduate training in public health to men and women who, on completion of the fellowship, are assured of posts in the public health service of the country from which they come. New York: The Rockefeller Foundation, 1939.




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## COMPONENT SOCIETIES BY DISTRICTS — FLORIDA MEDICAL ASSOCIATION

| Dis-<br>tricts                                   | COUNTY<br>SOCIETIES                               | PRESIDENT                                                           | SECRETARY                                                          | MEETING<br>DATE                                                        | COUNCILOR<br>and Counties Not In-<br>cluded in First Column | Members |      |
|--------------------------------------------------|---------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------|---------|------|
|                                                  |                                                   |                                                                     |                                                                    |                                                                        |                                                             | Total   | Paid |
| Northwest District (A)<br>Pensacola<br>1940      | Bay                                               | Amsie H. Lisenby, M.D.<br>Panama City                               | William C. Roberts, M.D.<br>Panama City                            |                                                                        | A-1-'40<br>Carol C. Webb, M.D.<br>Pensacola                 | 11      |      |
|                                                  | Escambia                                          | Sidney G. Kennedy, M.D.<br>511 American Nat. Bk. Bldg.<br>Pensacola | W. E. Tugwell, M.D.<br>Box 860<br>Pensacola                        | 2nd Tuesday<br>8:00 P. M.                                              |                                                             | 43      |      |
|                                                  | Walton-Okaaloosa                                  | A. G. Williams, M.D.<br>Lakewood                                    | R. B. Spire, M.D.<br>DeFuniak Springs                              | 3rd Thursday<br>8:00 P. M.                                             |                                                             | 6       | 100% |
|                                                  | Washington-Holmes                                 | W. D. Ranusey, M.D.<br>Nona                                         | L. H. Paul, M.D.<br>Bonifay                                        |                                                                        | Santa Rosa                                                  | 8       |      |
|                                                  | Franklin-Gulf                                     | Chapman Dykes, M.D.<br>Carrabelle                                   | A. L. Ward, M.D.<br>Port St. Joe                                   | 3rd Thursday                                                           | A-2-'41<br>B. A. Wilkinson, M.D.<br>Tallahassee             | 6       |      |
|                                                  | Jackson                                           | C. J. Price, M.D.<br>Alford                                         | R. N. Joyner, M.D.<br>Marianna                                     | 2nd Tuesday<br>7:30 P. M.                                              |                                                             | 12      |      |
|                                                  | Leon-Gadsden-Liberty-<br>Wakulla-Jefferson        | Francis T. Holland, M.D.<br>208 Midyette-Moor Bldg.<br>Tallahassee  | B. A. Wilkinson, M.D.<br>Telephone Bldg.<br>Tallahassee            | Quarterly<br>3:00 P. M.                                                | Calhoun                                                     | 37      | 5    |
| North Central District (B)<br>Lake City<br>1940  | Columbia                                          | L. J. Arnold, Jr., M.D.<br>Lake City                                | Harry S. Howell, M.D.<br>Blanche Hotel Annex<br>Lake City          | 1st Monday<br>7:30 P. M.                                               | B-3-'41<br>W. S. Nichols, M.D.<br>Lake City                 | 20      |      |
|                                                  | Madison                                           | E. Long, M.D.<br>Madison                                            | A. F. Harrison, M.D.<br>Madison                                    |                                                                        |                                                             | 3       |      |
|                                                  | Taylor                                            | Geo. H. Warren, M.D.<br>Perry                                       | Ralph J. Greene, M.D.<br>Perry                                     | Last Friday<br>8:00 P. M.                                              | Baker-Dixie-Hamilton-<br>Lafayette-Suwannee                 | 7       |      |
|                                                  | Alachua                                           | J. E. Maines, Jr., M.D.<br>433 E. Main St. N.<br>Gainesville        | J. Maxey Dell, Jr., M.D.<br>333 W. Main St. S.<br>Gainesville      | 2nd Friday<br>7:30 P. M.                                               | B-4-'40<br>James L. Strange, M.D.<br>McIntosh               | 29      |      |
|                                                  | Marion                                            | Henry C. Dozier, M.D.<br>9 No. Magnolia St.<br>Ocala                | R. C. Cumming, M.D.<br>Commercial Bank Bldg.<br>Ocala              | 3rd Thursday<br>12:30 P. M.                                            |                                                             | 23      | 100% |
|                                                  | Pasco-Hernando-Citrus                             | Wm. H. Walters, Jr., M.D.<br>Lacoochee                              | G. R. Creekmore, M.D.<br>Brooksville                               | 2nd Thursday<br>7:00 P. M.                                             |                                                             | 11      |      |
|                                                  | Sumter                                            |                                                                     |                                                                    |                                                                        | Bradford-Gilchrist-<br>Levy-Union                           | 2       |      |
| N. E. District (C)<br>Daytona Beach<br>1940      | Duval                                             | Chas. B. Mabry, M.D.<br>439 St. James Bldg.<br>Jacksonville         | Lauren M. Sompayrac, M.D.<br>459 St. James Bldg.<br>Jacksonville   | 1st Tuesday<br>8:15 P. M.                                              | C-5-'41<br>R. B. McIver, M.D.<br>Jacksonville               | 177     | 29   |
|                                                  | St. Johns                                         | R. D. Harris, M.D.<br>St. Augustine                                 | G. Walter Potter, M.D.<br>East Coast Hospital<br>St. Augustine     | 3rd Tuesday<br>8:30 P. M.                                              | Clay-Nassau                                                 | 11      |      |
|                                                  | Putnam                                            | Edward W. Ford, M.D.<br>Crescent City                               | C. M. Knight, M.D.<br>Palatka                                      | 2nd Tuesday in<br>Feb., April, June,<br>Aug., Oct., Dec.<br>7:00 P. M. | C-6-'40<br>George M. Green, M.D.<br>Daytona Beach           | 11      |      |
|                                                  | Volusia                                           | L. V. L. Brown, M.D.<br>DeLand                                      | R. L. Miller, M.D.<br>258½ S. Beach St.<br>Daytona Beach           | 2nd Tuesday<br>7:30 P. M.                                              | Flagler                                                     | 40      |      |
|                                                  | Hillshorough                                      | John R. Boling, M.D.<br>1207 First Nat. Bk. Bldg.<br>Tampa          | James S. Grable, M.D.<br>811 Citizens Bank Bldg.<br>Tampa          | 1st Tuesday<br>8:00 P. M.                                              | D-7-'41<br>W. C. McConnell, M.D.<br>St. Petersburg          | 106     |      |
| Southwest District (D)<br>Dunedin<br>1940        | Manatee                                           | S. G. Hollingsworth, M.D.<br>451 12th St.<br>Bradenton              | M. M. Harrison, M.D.<br>Professional Bldg.<br>Bradenton            | 3rd Tuesday<br>7:00 P. M.                                              |                                                             | 14      |      |
|                                                  | Pinellas                                          | John A. Herring, M.D.<br>259 Third St., No.<br>St. Petersburg       | W. C. McConnell, M.D.<br>313 First Federal Bldg.<br>St. Petersburg | 1st and 3rd Fridays<br>6:30 P. M.                                      |                                                             | 104     | 65   |
|                                                  | Sarasota                                          | T. W. Taylor, M.D.<br>Professional Bldg.<br>Sarasota                | Stanley T. Martin, M.D.<br>Sarasota                                | 2nd Tuesday<br>8:30 P. M.                                              |                                                             | 15      |      |
|                                                  | DeSoto-Hardee-High-<br>lands-Charlotte-<br>Glades | Ben D. Spears, M.D.<br>Wauchula                                     | Howard V. Weems, M.D.<br>22 Oak St.<br>Sebring                     | 2nd Tuesday<br>8:00 P. M.                                              | D-8-40<br>Herman Watson, M.D.<br>Lakeland                   | 20      |      |
|                                                  | Lee                                               | C. Gordon Merrick, M.D.<br>26 Leon Bldg.<br>Fort Myers              | H. L. Allan, M.D.<br>312 Pythian Bldg.<br>Fort Myers               | 3rd Friday<br>7:30 P. M.                                               |                                                             | 13      |      |
|                                                  | Polk                                              | Henry Fuller, M.D.<br>Mulberry                                      | Jere W. Annis, M.D.<br>Box 1021<br>Lakeland                        | 2nd Wednesday<br>1:00 P. M.                                            | Collier-Hendry                                              | 62      |      |
|                                                  | Brevard                                           | W. J. Creel, M.D.<br>Eau Gallie                                     | I. K. Hicks, M.D.<br>Melbourne                                     | 3rd Tuesday                                                            | E-9-'40<br>W. C. Page, M.D.<br>Cocoa                        | 9       |      |
| South Central District (E)<br>Ft. Pierce<br>1940 | Lake                                              | W. L. Ashton, M.D.<br>Umatilla                                      | Olliver Emerson, M.D.<br>Tavares                                   | 1st Thursday<br>12:30 P. M.                                            |                                                             | 17      |      |
|                                                  | Orange                                            | C. D. Hoffmann, M.D.<br>120 E. Robinson St.<br>Orlando              | Fred Mathers, M.D.<br>Box 53<br>Orlando                            | 3rd Wednesday<br>8:30 P. M.                                            |                                                             | 84      |      |
|                                                  | Seminole                                          | Wm. H. Garner, M.D.<br>Sanford                                      | Douglas G. Scott, M.D.<br>212 N. Park Ave.<br>Sanford              | 2nd Monday<br>7:00 P. M.                                               | Osceola                                                     | 12      |      |
|                                                  | St. Lucie-Okeechobee<br>Indian River-Martin       | J. D. Parker, M.D.<br>Box 942<br>Stuart                             | Adrian M. Sample, M.D.<br>Ft. Pierce                               | 3rd Thursday<br>8:00 P. M.                                             | E-10-'41<br>A. M. Sample, M.D.<br>Ft. Pierce                | 18      |      |
|                                                  | Broward                                           | L. B. Elliston, M.D.<br>814 Sweet Bldg.<br>Ft. Lauderdale           | E. C. Chamberlain, M.D.<br>720 Sweet Bldg.<br>Fort Lauderdale      | 4th Wednesday<br>8:00 P. M.                                            | F-11-'40<br>Lloyd J. Netto, M.D.<br>West Palm Beach         | 36      | 2    |
| S. E. District (F)<br>Key West<br>1940           | Palm Beach                                        | James H. Pittman, M.D.<br>Box 602<br>W. Palm Beach                  | C. Jennings Derrick, M.D.<br>Box 574<br>W. Palm Beach              | 4th Monday<br>8:00 P. M.                                               |                                                             | 61      |      |
|                                                  | Dade                                              | Joseph S. Stewart, M.D.<br>1105 Huntington Bldg.<br>Miami           | Franz Stewart, M.D.<br>1105 Huntington Bldg.<br>Miami              | 1st Tuesday<br>8:30 P. M.                                              | F-12-'41<br>Kenneth Phillips, M.D.<br>Miami                 | 292     |      |
|                                                  | Monroe                                            | Harry C. Galey, M.D.<br>532 Fleming St.<br>Key West                 | W. R. Warren, M.D.<br>511 Eaton St.<br>Key West                    | 1st Sunday<br>9:00 P. M.                                               |                                                             | 4       |      |



STATE AND SECTIONAL MEETINGS

| SOCIETY                             | PRESIDENT                           | SECRETARY                              | ANNUAL MEETING                   |
|-------------------------------------|-------------------------------------|----------------------------------------|----------------------------------|
| Florida Medical Association.....    | Leigh F. Robinson, Ft. Lauderdale   | Shaler Richardson, Jacksonville...     | Tampa, Apr. 29, 30 & May 1, 1940 |
| Florida Medical Districts:          |                                     |                                        |                                  |
| A—Northwest .....                   | B. A. Wilkinson, Tallahassee...     | Stewart Thompson, Jacksonville...      | Pensacola, 1940                  |
| B—North Central .....               | William S. Nichols, Lake City...    | " " "                                  | Lake City, 1940                  |
| C—Northeast .....                   | Robt. B. McIver, Jacksonville...    | " " "                                  | Daytona Beach, 1940              |
| D—Southwest .....                   | W. C. McConnell, St. Petersburg...  | " " "                                  | Dunedin, 1940                    |
| E—South Central .....               | A. M. Sample, Ft. Pierce.....       | " " "                                  | Ft. Pierce, 1940                 |
| F—Southeast .....                   | Kenneth Phillips, Miami .....       | " " "                                  | Key West, 1940                   |
| Alabama Medical Association.....    | M. S. Davie, Dothan.....            | D. L. Cannon, Montgomery .....         | Birmingham, April 16-18, 1940    |
| Georgia, Medical Assn. of .....     | W. H. Myers, Savannah.....          | E. D. Shanks, Atlanta.....             | Savannah, April 23-26, 1940      |
| Florida—                            |                                     |                                        |                                  |
| State Dental Association.....       | E. B. Penn, Miami.....              | E. C. Lunsford, Miami.....             | St. Petersburg, Nov., 1940       |
| Soc. of Derm. and Syph.....         | Alan Brown, Jacksonville.....       | Lauren M. Sompayrac, Jacksonville...   | Tampa, 1940                      |
| East Coast Medical Association..... | I. M. Hay, Melbourne.....           | J. S. Stewart, Miami.....              | Miami, 1940                      |
| State Hospital Association.....     | J. H. Therrell, Chattahoochee...    | Mr. Fred M. Walker, Jacksonville...    | Mississippi, March, 1940         |
| Assn. of Industrial Surgeons.....   | Harrison A. Walker, Miami Beach...  | A. M. Bidwell, Tampa.....              | Tampa, Apr. 29, 1940             |
| Internists' Society.....            | Norval M. Marr, St. Petersburg...   | Kenneth Phillips, Miami.....           | Tampa, Apr. 29, 1940             |
| Medical Postgraduate Course...      | Turner Z. Cason, Jacksonville....   | Chairman                               | Jacksonville, 1940               |
| Soc. of Ophthal. & Otol.....        | S. B. Forbes, Tampa.....            | Temporary Chairman.....                | Tampa, Apr. 29, 1940             |
| State Nurses Association.....       | Mrs. M. Stetson, St. Petersburg...  | Mrs. Phyllis Leonard, St. Augustine... |                                  |
| Pediatric Society .....             | Warren W. Quillian, Coral Gables... | G. N. Leonard, Miami Beach.....        | Tampa, 1940                      |
| Pharmaceutical Association .....    | Mr. S. F. Harris, Jacksonville...   | Mr. A. W. Morrison, Miami.....         | Tampa, May, 1940                 |
| Public Health Association .....     | A. B. McCreary, Jacksonville....    | E. M. L'Engle, Jacksonville.....       | Tampa, Dec., 1940                |
| Radiological Society .....          | H. B. McEuen, Jacksonville.....     | J. N. Moore, Ocala.....                | Tampa, Apr. 29, 1940             |
| Railway Surgeons' Association...    | H. D. Clark, Ft. Pierce.....        | W. C. Page, Cocoa.....                 | Tampa, Apr. 28, 1940             |
| Tuberculosis & Health Assn.....     | Mr. G. E. Therry, W. Palm Beach...  | Mrs. May Pynchon, Jacksonville...      | Spring, 1940                     |
| Chattahoochee Valley Med. Assn...   | M. Y. Dabney, Birmingham.....       | Frank K. Boland, Atlanta.....          | Albany, Ga., July 9-11, 1940     |
| Gulf Coast Clinical Society.....    | J. H. Dodson, Mobile.....           | C. C. Rouse, Mobile.....               |                                  |
| Southeastern Derm. Assn.....        | Jack Jones, Atlanta.....            | Howard Hailey, Atlanta.....            | Atlanta, Ga., Sept. 1, 1940      |
| Southeastern Surgical Congress...   | R. L. Sanders, Memphis.....         | B. T. Beasley, Atlanta.....            | Birmingham, Mar. 11-13, 1940     |
| Southern Medical Association.....   | Arthur T. McCormack, Louisville...  | Mr. C. P. Loranz, Birmingham....       | Louisville, Ky., Nov., 1940      |
| Swanensee River Medical Society...  | T. H. Bates, Lake City.....         | H. S. Howell, Lake City.....           |                                  |

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Florida Medical Association, Tampa, April 29, 30, and May 1, 1940  
Southern Medical Association, Louisville, Ky., November, 1940

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# STUDIES IN THE AVITAMINOSES

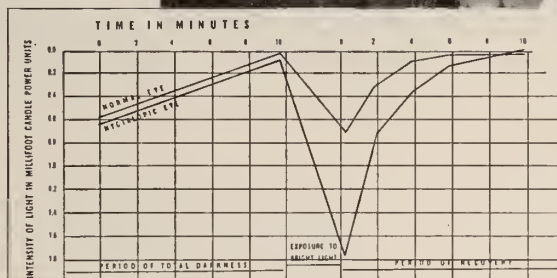


This page is the second of a series on vitamin deficiencies presented by the research division of The Upjohn Company because of the profession's widespread interest in the subject. A two-page insert on the same subject appears in the February 17 issue of The Journal of the American Medical Association.

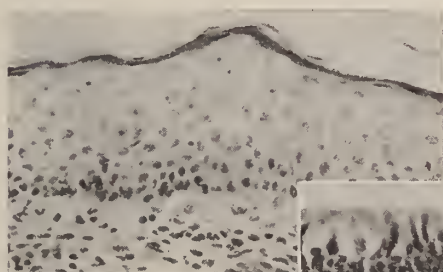
## Manifestations of Vitamin A Deficiency

One of the early manifestations of vitamin A deficiency is nyctalopia, a loss of visual acuity in dim light. While several pathologic states (retinitis pigmentosa, toxic amblyopia, detachment of the retina) also produce night blindness, vitamin A deficiency is probably the most frequent cause. After exposure to the blinding glare of a bright light the normal eye adapts itself relatively quickly to lowered illumination. In nyctalopia due to vitamin A deficiency, the time required for recovery of visual acuity is longer.

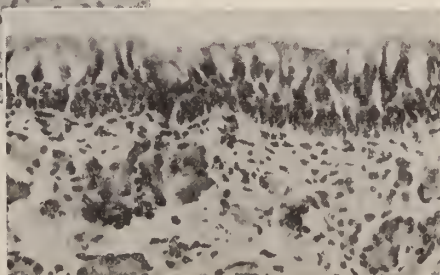
In otherwise normal eyes, measurement of capacity for dark adaptation by means of the biophotometer has been suggested as a method of discovering vitamin A deficiency.



Lower line shows the longer time required for the recovery to pre-exposure level by the nyctalopic.



Above, stratified, keratinizing epithelium of the turbinate mucous membrane of a vitamin A deficient monkey; at right, normal mucosa.



Pathologic epithelial changes produced by vitamin A deficiency are illustrated by the photomicrographs of turbinate mucous membrane taken from normal and vitamin A deficient monkeys. The progressive pathologic process consists of atrophy of the epithelium, reparative proliferation of the basal cells and finally, as depicted in the upper photograph, replacement of the normal by a stratified, keratinizing epithelium.

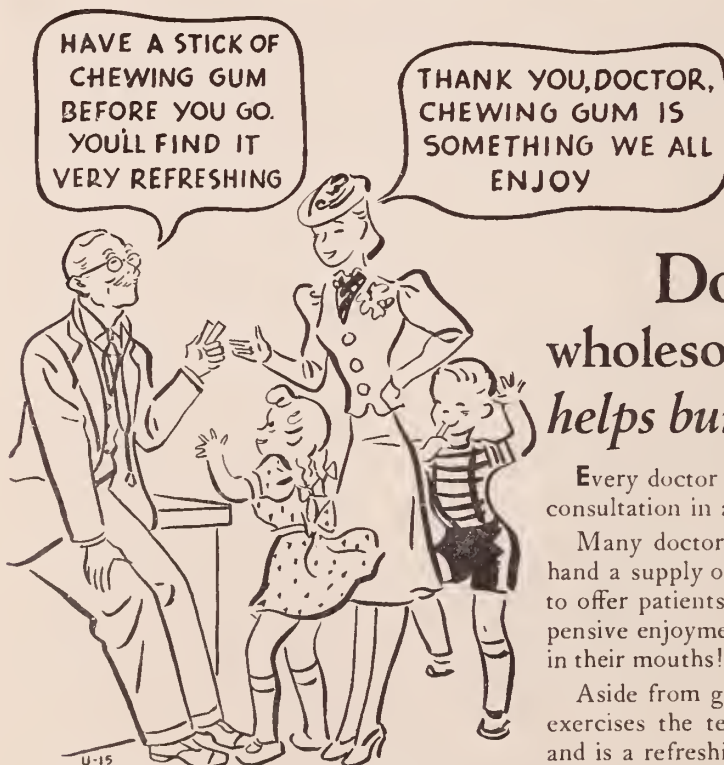




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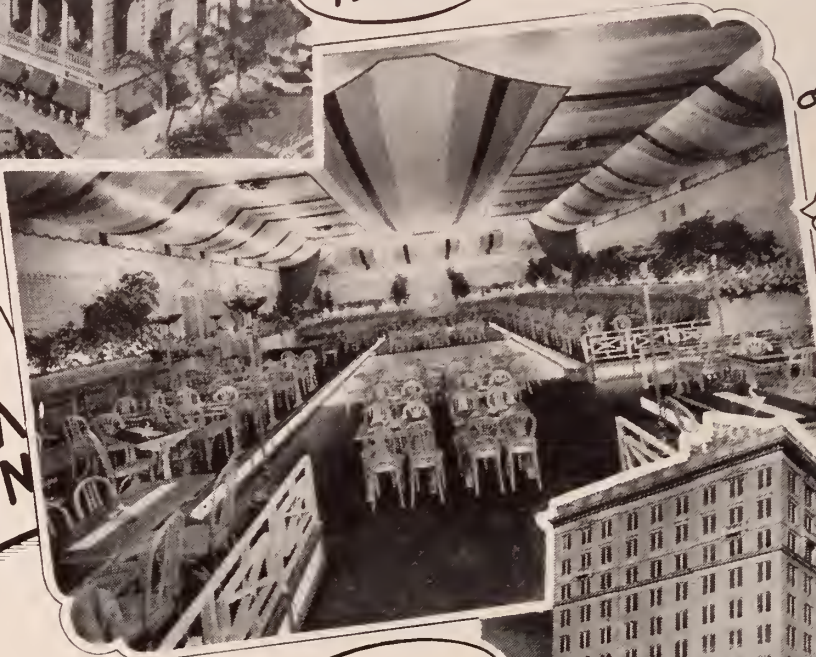
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## ACUTE APPENDICITIS

LLOYD J. NETTO, M. D.  
West Palm Beach

Since J. B. Murphy began to emphasize the need for recognition of the symptoms and early operation for cases of "typhilitis, perityphilitis and perityphlitic abscess," many volumes have been written and countless hours of honest work spent in an effort to conquer this most common of all surgical conditions, and lessen the unjustified toll of human lives resulting therefrom.

Yet in spite of the rapid strides made in the improvement of surgical technique, the standardization of various anesthetic substances, the improvement in diagnostic measures, and the wealth of knowledge accumulated in the fields of bacteriology, pathology and other allied branches of medicine, we are still compelled to acknowledge the appalling total of nearly 20,000 deaths yearly from acute appendicitis in the United States.

Dealing with a condition about which there is so much common knowledge among physicians concerning the cardinal points of diagnosis and treatment makes this a difficult one to discuss. Furthermore, we realize that in the short time allotted it is impossible to cover in much detail the many phases of a subject so wide in scope as this. However, because of the continued high death rate under conditions so much improved over those existing thirty years ago, no apologies are offered for discussing such an important problem.

To proclaim that any of the material presented in this paper is new would be an admission of ignorance of the entire subject. Neither is a claim to be made that a definite solution of the problem of acute appendicitis and a specific remedy for relieving its high mortality rate are offered and to be found in these pages.

The purpose of this paper is: to discuss the present status of treatment, to review mortality statistics, and to present a report of the cases of acute appendicitis which came to operation at the Good Samaritan Hospital in

West Palm Beach during the past five years. To supply a basis for discussion of the present status of treatment, questionnaires were sent to a number of medical centers and outstanding clinics, representing a fair cross-section of the country. Opinions were sought on the more controversial points in the management of the disease in question: (1) the choice between immediate operation or conservative treatment in delayed cases; (2) the manner of dealing with the stump at the time of operation; (3) whether to remove the appendix in abscessed cases, or treat by simple drainage at the time and remove the appendix later; and (4) the use or non-use of drains.

As was anticipated, the opinion was unanimous in stressing early operation in the typical acute case apparently not ruptured. This is not to be disputed for if we could find some means through public education and elimination of delay by physicians first seeing the cases to get all patients to surgery in the first few hours after initial symptoms appear, we would have gone a long way toward solving the problem presented by this disease which ranks so high in the production of death. The time element is not alone the deciding factor in the production of a perforate appendix. It is not uncommon to operate upon a patient who has come to the operating table in the first few hours and to find that his is a fulminating type of infection, the appendix having ruptured and its liquid contents or a fecolith discharged into the peritoneal cavity. But with the time element greatly shortened in the average case, there is bound to be much less chance for the other forces contributing to rupture to exert their influence. By this is meant that the greater the interval between the onset of pain and the beginning of the operation, the greater is the opportunity for the consumption of cathartics at home or at the corner drug store, the giving of vigorous enemas and the administration of sedatives for pain, all of which play an active part in the production of rupture and subsequent peritonitis.

As to the question of immediate operation or use of the conservative treatment according to the Ochsner plan, the opinion varies, but with the majority of those men con-

tacted, this plan is reserved or advocated for the very ill patients with unmistakable evidence of general peritonitis, who present symptoms of dehydration, tachycardia, gastric and intestinal dilatation and shock. The length of delay of operation depends upon the change in general and local conditions. Notably in this group are found the cases which demand the utmost in preoperative treatment and preparation, if operation is to be done with a reasonable hope for cure. In these patients the peritonitis is the thing of most importance and, to quote from Alton Ochsner,<sup>2</sup> "the acute appendix becomes relatively insignificant." Treatment herein includes the Fowler position, nothing to be given by mouth, the relief of distention by duodenal tube with the Wangenstein or similar apparatus, and administration of 5 per cent glucose in saline or Ringer's solution by the intravenous route, or saline by hypodermoclysis. From the Mayo<sup>3</sup> clinic success is reported with the use of high concentration oxygen inhalations to combat the toxins from anaerobic bacteria which are believed to be largely responsible for death in peritonitis. The rationale is that in addition to combating the anaerobic factor oxygen serves to displace nitrogen with which the distended bowel as well as the blood stream is supersaturated. With the nitrogen displaced the venous blood supply becomes improved and the distention relieved. The use of the pentavalent anaerobic antisera has also met with encouraging results in their hands.

When with these and other appropriate measures the general condition is improved, the anhydremia overcome and the pathologic processes are localized, operation is to be carried out. There is no doubt that many patients of this type are lost in the eagerness of haste, who might be saved by delay of operation for a few hours or longer to replace the body fluids and bring about an improvement in the general condition, thereby lessening the operative risk.

While the above resume represents a majority opinion, there are some very outstanding surgeons who advise immediate operation in all cases regardless of the time or stage of the disease. Horsley<sup>4</sup> says: "Operate upon every case of appendicitis, or peritonitis from appendicitis, as soon as the diagnosis is

made." Some others delay only long enough to reestablish water and salt balance in the blood, and operate in all cases where the general condition permits.

The choice of treatment in those late cases where apparently there is rupture but without definite signs of general peritonitis, presents the problem which taxes the experience and judgment of the individual surgeon to the utmost. There can be no fixed rule and each case becomes a law unto itself. It is difficult to determine always whether the appendix has ruptured and how much involvement of the peritoneum is present. While the answers to my questionnaire show a general agreement as to principle, there is a variance as to what constitutes reason for conservative treatment of a given case, with not sufficient positive statements to draw a conclusion as to the consensus unless it is said that in cases showing signs of localization, the majority are content to wait until the operation will consist of draining a definite abscess.

The removal of the appendix in walled-off abscesses is generally advocated unless it is so inaccessible or so difficult of removal as to necessitate breaking up of adhesions or tearing through the abscess wall, soiling the general peritoneal cavity. In those cases where treatment is simple drainage the appendix should be removed at a later date, several weeks after recovery. This is not always possible, however, because the patient does not readily submit to the second operation.

The manner of dealing with the stump shows the greater number to favor some form of burying the exposed portion remaining on the wall of the cecum, except in cases where the adjacent wall is thickened and unyielding or is very friable. The most common procedure is invagination with a purse-string suture after the stump has been ligated. Opposed to this method are those who practice ligation and covering over the stump with the meso-appendix. My preference is inversion without ligation. This technique has been described by Ochsner and Lilly in *Surgery*, October, 1937,<sup>5</sup> wherein they express belief that it prevents the danger of blowout through the stump, or the formation of abscesses in the wall of the cecum. The main objection is the likelihood of postoperative hemorrhage into the cecum. I prefer this method, and have used it in



twenty-five or more cases without cause for regret.

It is not possible to drain the entire peritoneal cavity *per se*, but drainage is effective at the site of local contamination. In all cases of perforation where the field is not completely dry, where local peritonitis is present, or where there is actual pus or necrotic tissue present in the peritoneal cavity, it is safer to drain. Many surgeons advocate drains down to the peritoneum in doubtful cases to prevent spread of infection in the abdominal wall due to contamination during the operation. In late cases of rupture with evidence of spreading peritonitis and presence of pus, adequate drainage left in sufficiently long is a valuable procedure. The majority of surgeons today, I believe, favor closing without drainage in doubtful cases.

While in the average case of early acute appendicitis without rupture there is no need of special after care other than rest, sedation, catheterization and good nursing, the prompt institution of appropriate measures in the complicated case is essential if the patient is to be spared his life. Rest is important and is to be accomplished not alone by sedatives but also by spacing the necessary treatments such as hypodermic medication, catheterizations, etc., so that the patient is disturbed as little as possible. With expert nursing this can be done in such a way that the patient is not conscious that these measures are being carried out. Intravenous solutions of saline or 5 per cent glucose are given until sufficient nourishment can be taken by mouth. The distended bowel is relieved by continuous duodenal suction, and the specific measures previously mentioned for peritonitis are to be resorted to.

Whether the type of anesthesia used is a factor strongly influencing the outcome of cases operated upon for acute appendicitis is yet to be decided and is probably not emphasized in the literature as much as it might be. In this connection I present for discussion the figures from two recent reports. Bliss and Heaton, from a study of the records of Station Hospital, Fort Sam Houston, Texas,<sup>6</sup> analyze a series of 2,100 operations performed from 1931 to 1936, for all types of acute appendicitis. In this series there were ten deaths, or a mortality rate of 0.47 per cent. Aside from the fact that these cases all come to sur-

gery early, they believe that the routine use of spinal anesthesia is a factor greatly influencing their low death rate. At the Jackson Clinic, Madison, Wisconsin,<sup>7</sup> a recent review showed that from 1922 to 1931 their mortality rate from cases of acute perforative appendicitis was 13.0 per cent, and following the routine introduction of spinal anesthesia in 1928 there have been only two deaths in 40 cases, and no deaths at the clinic from appendicitis since 1931. Credit for the major part in this reduction is given to spinal anesthesia.

From 1934 to 1938 inclusive, 414 patients with acute appendicitis were operated upon at the Good Samaritan Hospital in West Palm Beach. These operations were performed by the various members of the staff, and include all types of acute cases. In this series were 27 cases of perforation and 10 cases of localized abscess. These patients were all submitted to immediate operation as soon as the diagnosis was made. The average elapsed time between initial symptoms and operation was 29 hours; 219 were males and 195 females.

The manner of dealing with the stump was in 204 cases invagination or inversion and, in the remaining 210, simple ligation.

Drains were used in 108 of the series and 306 were closed without drainage. The average postoperative hospital stay was 12.1 days. Of the 414 cases, there were 20 deaths, giving a mortality rate over the 5 years' period of 4.8 per cent. Analysis of the deaths showed that the average elapsed time between onset and operation in this group was 91.6 hours, and nearly all these patients had taken purgatives before a diagnosis was made. Fourteen were cases of rupture and one of localized abscess.

Cause of death was given as follows:

|                                                                  |          |
|------------------------------------------------------------------|----------|
| Peritonitis                                                      | 13       |
| Pulmonary embolus                                                | 3        |
| Ileus                                                            | 1        |
| Multiple liver abscesses                                         | 1        |
| Hemorrhage from throat following tonsillectomy done at same time | 1        |
| Gastro-intestinal hemorrhage, blood dyscrasia                    | 1        |
|                                                                  | <hr/> 20 |

The mortality in ruptured cases including localized abscesses, was 35.1 per cent. The average elapsed time before diagnosis was made and operation performed in this small group of cases of ruptured appendicitis, to-

gether with the high incidence of taking purgatives, emphasizes the tremendous task confronting the surgeon unless people can be educated to the importance of a "hands-off" policy for home remedies and procrastination in dealing with abdominal pain.

A review of the mortality statistics for the entire United States, revealed that from 1912 through 1931 there was a gradual rise in death rate per 100,000 population, and from 1931 a steady decline. The mortality rate for 1937 was 11.9, 15,340 in number, which is the lowest since 1918. In some sections of the country there has been marked decrease in the number of deaths per 100,000 population, but in others a decided rise. However, it remains the fact that statistics show that in spite of the improvement in diagnostic methods, anesthesia, surgical technique and post-operative care the death rate per unit of population in the United States is higher than it was thirty-five years ago.

The conclusion to be drawn from this discussion is that if we are to succeed in a material reduction of mortality it is essential to train the public to abide by a few simple rules in the presence of abdominal pain, namely:

1. Avoid cathartics and vigorous enemas.
2. Take only fluids by mouth.
3. Withhold sedatives of all kinds until a diagnosis is made.
4. Consult a competent physician as early as possible after the onset.

#### SUMMARY

1. Discussion of the present status of the treatment of acute appendicitis is offered.
2. Four hundred fourteen cases of acute appendicitis which came to operation at the Good Samaritan Hospital in West Palm Beach, Florida, are summarized.

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416 Comeau Building.

#### DISCUSSION

*Dr. Harrison A. Walker, Miami Beach:*

Since Doctor Lilly could not be here Doctor Netto asked me to discuss his paper. It is a very excellent presentation and well-prepared paper. I have not had time to make any written discussion, but will try to touch on a few points which I would like to emphasize.

Regarding early diagnosis and delayed or immediate operation, I believe that particular subject is one that will have to be decided personally. I agree with the early operators on that. I think we might make our comparison with the intestinal obstruction case. It has been said by one of our teachers that the time to operate for intestinal obstruction is as soon as you make up your mind that it is intestinal obstruction. As brought out in a paper presented at this meeting last year, there are some deviations from that old axiom in that we feel it necessary to see that the patient is properly prepared for operation so that he may be a better risk. We give him fluids and other things which we happen to know might give him a better chance for recovery and lower our mortality.

As to the manner of dealing with the stump, I think that the point brought out by Doctor Netto was well taken. I have not inverted a stump for quite some time. Of course the point brought out by Doctor Netto of not ligating the stump before invagination is worth considering.

As to drainage: There, of course, are two schools of thought on that subject. I believe that there is leaning toward not draining the cavity or possibly down to the fascia if there is a possible chance of the wound being infected.

As to the anesthesia: I just happen to have a little special tendency toward cyclopropane with intravenous pentothal sodium. Spinal anesthesia is well worth while in certain hands.

*Dr. Don C. Robertson, Orlando:*

I wish first of all to express my appreciation for the privilege of discussing Doctor Netto's splendid paper on this subject. In the very limited time allowed him he has again brought to our attention this all important subject, which causes a loss of approximately 20,000 lives annually in this country, the highest mortality rate in any of the civilized nations. I wish to particularly emphasize that in general there has been no appreciable decline in the mortality of acute appendicitis during the past twenty years, and yet over a thousand articles have been written on this subject during the past six years.

Doctor Netto wisely set forth and discussed some of the most controversial points and summarized the opinions of the leading men in the different sections of the country.

The mortality rate of 4.8 per cent in this series of acute appendicitis which includes 27 perforated cases and 10 with localized abscess compares very favorably with many published reports, and yet it is not as low as we would like to see it.

In regard to the controversy among surgeons as to the proper time to operate in cases of acute perforated appendicitis, it has been our rule to operate immediately after a diagnosis of acute appendicitis has been made, unless the patient is practically moribund. I would like to state here, however, that although we say immediately, we certainly allow time for restoration of fluids and chlorides and, if necessary, for transfusions with blood. We always remove the appendix in every case where the condition of the patient permits.

In dealing with the stump, we definitely favor the method of ligation and inversion. Ligation around the crushed base of the appendix prevents the possibility of postoperative hemorrhage into the cecum. We believe that the formation of abscesses and blowouts in the inverted stump can largely be prevented if a fine ligating suture of catgut is used and the suture cut flush with the knot when tied. Should an abscess form, the suture will give way very easily and allow for discharge into



the cecum. We have seen none of these complications in over 1,000 appendectomies where the ligation and inversion method was used.

I am an ardent exponent of the McBurney incision and of the opinion that the proper use of this incision will lower the mortality rate very considerably.

I would like to ask Doctor Netto what types of incisions were used in the majority of these cases.

I have just reviewed my own personal series of 110 cases of acute appendicitis operated at the Henry Ford Hospital in Detroit, Michigan. The mortality was 1.8 per cent. These figures very closely approximate a recent report by Drs. Roy D. McClure and William Altemeier of the above hospital in a series of 205 cases of acute appendicitis both ruptured and unruptured with a mortality of 1.5 per cent.

#### *Dr. Lloyd J. Netto (Concluding):*

As I stated in the beginning, one cannot discuss appendicitis in fifteen minutes; there are so many things that may be brought up and discussed, all with good points, about this particular disease.

What I had hoped to do in pointing out different types of cases was to help us to get people thinking about it, watching their own statistics and their own cases and deciding how they are going to be handled. There are favorable statistics both ways, that is, in the matter of operating immediately regardless of whether there is peritonitis or not, and in the conservative management. Every fellow thinks his method is best. They all have statistics which show good results.

As I mentioned before, at the Army Hospital they reviewed a series of cases in all of which an early diagnosis was made, within at least 24 hours, and their statistics showed a mortality of .47 per cent. Horsley at his own clinic at Richmond, which is privately owned, run on an even course year in and year out with his own technique and staff, reports an almost equally good low mortality rate of about .66 per cent. I talked to him last Fall and his mortality rate had not changed in acute appendicitis cases in recent years.

Therefore it is probably a matter of personal opinion and will have to be worked out on that basis. However, I think a lot can be done by not being in too big a hurry to operate, but in taking at least a few hours to get the patient in better shape.

I had hoped that somebody would discuss anesthesia. I have not had enough personal experience to argue as to which is the better. However, I do think that is one thing to be considered. These statistics I reported came out before cyclopropane was used so much.

One thing about the patients at Good Samaritan Hospital who died—we had 37 with ruptured appendix and all, or most of them, came in from outlying sections. That is a very important thing to consider when discussing the mortality of acute appendicitis. There is no question about it; when you get patients that come in 50 or 100 miles in automobiles or other conveyances with acute appendicitis it is going to contribute to some extent to the number of ruptures.

As to the technique of inversion: I first saw that done about 1932 or 1933 by Doctor Percy, at Chicago. In his talk while operating, he stated that his reason for using this manner of dealing with the stump was the fact that he had had at least two cases in some 3,000 or more of acute appendicitis wherein he had to resect the cecum for abscess that developed later on. Had he said that he had 200 in 3,000 or 20 in 3,000, I would not have believed him quite as readily. This method impressed me thoroughly and I started using it. He used silk and made two purse strings instead of just one. After the first was finished he made the second one using a portion of the meso-appendix as an anchor for the suture. This gives a secure knot and the inversion is much more complete.

There are one or two things I would like to mention that came to me in the preparation of this paper. Even though everybody within the sound of my voice may know as much about the subject as I do, I still think

appendicitis cannot be emphasized too much. In this day of so much newspaper medicine, patients are getting to the point where they think they are just as capable of making a diagnosis as their own family physician. If they go to a surgeon it is going to cost money and take time and they don't want to go into the surgeon's office because he always has a sharp knife handy and wants to cut. All of these things they consider. That is why I say you cannot emphasize too much the importance of avoiding these things that contribute toward rupture of the appendix, subsequent peritonitis and other complications.

One of the most important things I think that should be emphasized in the matter of trying at least to educate our own patients and the general public as well, is to stay away from the corner drug store when they get a pain in the belly. There is no question in the world that a lot of these things are caused from cathartics taken at home or at the drug store. You know as well as I that a number of druggists are practicing medicine and they have a larger practice than some of us do as to the number of patients coming in and asking for relief. I have known of at least one or two cases where the ruptured appendix resulted from a dose of castor oil taken in the drug store and given by the druggist. The most dangerous thing is the drug clerk with three or four months' experience who feels his importance and thinks he knows enough to prescribe medicine.

Another thing to be stressed is not to give morphine to these patients when they are seen by the doctor about one or two o'clock in the morning and he wants to get back home and go to bed.

As to the type of incision used in these cases I reported from the Good Samaritan Hospital: The types of incisions used were the McBurney and the paramedian or right rectus incisions, in about equal number.

## ACUTE INTESTINAL OBSTRUCTION

### DIAGNOSIS AND PHYSIOLOGIC TREATMENT

HUGH WEST, M. D.  
DeLand

The subject of intestinal obstruction is so extensive that only a very minute portion can be presented in fifteen minutes. Hence my remarks are to be limited to obstruction of the small bowel.

Each time the content of the abdomen is insulted by the surgeon's knife, an inflammatory lesion, a growth, or by any other invasion, a potential case of intestinal obstruction is created. Abdominal surgery has advanced, new phases discovered, old ones perfected, but acute obstruction of the small intestine has remained its most lethal affection.

I shall not mention any uninteresting mortality rates. Suffice it to say that the mortality rate is entirely too high, being estimated by various authors at from 60 to 80 per cent. This excessively high rate should be considered as a reflection on the medical profession for it is well known that patients operated upon

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early suffer only a 5 per cent mortality. Therefore, it behooves us to evaluate properly symptoms as presented by the patient and act immediately.

When we see any patient with colicky pains in the abdomen of over six hours' duration whose pain is getting progressively worse, the condition causing the pain should be considered obstruction until proved otherwise. This is particularly so if the abdomen presents a surgical scar. In obstruction the abdomen is tender, rigidity being absent unless the stoppage is complicated by an inflammatory lesion. In the absence of inflammation the abdomen presents to the gentle hand the sensation of kneading soft dough. There may or may not be a palpable mass. If the condition is of twenty-four or more hours' duration, dullness is usually found in the flanks, due to the presence of free fluid in the abdominal cavity. There is usually nausea and sometimes vomiting but most commonly a constant spitting up of gastric contents, which may even continue between vomiting spells. A duodenal tube passed through the nose and allowed to remain in place gives important evidence of intestinal reflux and some comfort to the patient. Visible peristalsis may be present if the abdomen is thin-walled and even the step-ladder coils of distended intestines may be seen. A flashlight held parallel to the long axis of the body so that the rays are nearly horizontal to the abdomen may make these signs more evident to the eye. Some authors feel that a flat x-ray plate of the abdomen is of great value in determining the presence or absence of an obstruction. From my experience I have found this only serves to cloud the issue. A contrast medium by mouth or by rectum is very definitely contraindicated.

On auscultating the abdomen gurgling sounds are heard which increase with the pain. These are produced by peristalsis acting on the gas and liquid within the closed tube. Clear tinkling sounds and accentuation of the pulsations of the abdominal aorta within an otherwise silent abdomen are late signs evident after the intestine has lost its tone, and should be more properly classified as signs of lost opportunity.

One or more enemas are usually given in the first six hours. The nurse often reports "good results." Subsequently more enemas are given and the report is "some flatus expelled." There

may be a small amount of gas expelled with a number of enemas or the enema may have to be removed by syphonage. I believe that more delay has been based on the results of enemas than from any other thing. Most often the gas comes from below the site of the obstruction. If the patient is not absolutely cured by one or two enemas or, at the most, three, further efforts along this line should be discontinued. In lieu of the multitude of enemas more valuable information can be obtained from the examining finger in the rectum. Codman called attention to a peculiar sensation felt by the finger in the rectum of an obstructed patient. There is a snug crowding of the folds of the rectum around the finger, and sometimes a distention may be felt higher up. This is a most important sign and pathognomonic, certainly when the symptoms described previously are present.

A study of the chemistry of the blood will show a decrease of chlorides, an increase of non-protein nitrogen and diminution in the combining power of  $\text{CO}_2$ . A moderate leukocytosis is present in earlier cases and a leukopenia of 2000 to 3000 cells is present in later cases and should be classified along with the silent abdomen as signs of lost opportunity. Examination of the urine shows definitely by the presence of granular casts and albumen that a nephrosis is present.

Few cases show all of the symptoms mentioned. The history is most important and, as Lord Moynihan said, "... a convincing, irrefutable clinical diagnosis is desirable but not really important." Doctor Finney has said: "It seems more logical to do a few more unnecessary exploratory operations on live patients than the long and melancholy roll of hurried enterostomies on moribund ones."

Robertson Ward in 1929 described continuous suction of the duodenum, Wangenstein in 1931 popularized it, and more recently Miller and Abbott have made experimental and clinical studies on intubation of the small intestine by means of a double lumen tube ten feet long. On the very end of this tube is an ordinary duodenal tip or bucket. Immediately back of this tip is a collapsible rubber bag capable of being inflated to hold 30 to 50 cc. of air. This tube is passed either through the nose or mouth as is the ordinary duodenal tube. When the tip has reached the mid-duodenum as shown by the fluoroscope or by the



presence of duodenal contents coming through the tube, a volume of 30 to 50 cc. of air is injected into the bag and the opening plugged. In the meantime, continuous suction is applied through the other larger lumen. As gas and fluid are sucked out of the gut, the intestinal walls contract and, regaining their normal propulsive movement, they force the balloon ahead. The suction likewise collapses the intestine, loop by loop, as the tip of the tube advances until the obstruction is reached, by which time relief of distention and with it relief of pain have occurred. The tube will advance at the rate of one foot an hour and will reach the cecum 8 or 10 feet from the teeth. In the meantime the patient's chlorides are replaced by intravenous injection of physiologic salt solution with 5 per cent dextrose for support. There is plenty of time for blood typing, transfusions, and deliberate management outlined. If the tube stops completely a small amount of dilute barium solution may be injected and x-rays made to further localize the obstruction.

When the intestine is thus decompressed a very much easier exploration can be done with much more safety to the patient. The operation should be done with the long tube in place and it should be allowed to remain in place to take care of any distention that might arise following operation.

Some may question the wisdom of spending several hours in coaxing the tube and bag down to the obstruction, fearing gangrene. Reliable statistics show that 5 per cent of cases are gangrenous and since the mortality is near 80 per cent without intubation, it would seem good practice to be not so hasty.

Indication for drugs in any abdominal pain before diagnosis is seldom indicated. Subsequent to a diagnosis of acute obstruction and until the obstruction is positively relieved, drugs other than an opiate for relief of pain or restlessness are absolutely contraindicated. Following removal of the obstruction, stimulating drugs if used should be used with fear and trembling and their effect very carefully watched.

In conclusion I would say that nothing offers more opportunity for studying the physiology of the gut, the chemistry of the blood, the mechanics of sound, and more opportunity to literally "snatch a patient from the jaws of death," than acute obstruction

properly handled. To Doctors Haden and Orr, Miller and Abbott and Wangensteen we are particularly indebted. The judicious use of the long tube, the maintenance of proper chemical and fluid balance in the body and a physiologic minded surgeon rather than a mechanically minded surgeon are factors that will serve to reduce the appalling mortality of acute obstruction of the small intestine.

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## DISCUSSION

*Dr. Joseph S. Stewart, Miami:*

Any discussion of obstruction of the small intestine must begin by dividing the subject into two types: (1) simple obstruction, and (2) obstruction with interference with the blood supply. The symptoms in the two types are different, and the treatment entirely different.

In simple obstruction the abdomen is not tender, there are no tender points on pressure. In my experience point tenderness means interference with the blood supply and is the sign that to me demands immediate operation. Contrariwise, if there is no tenderness, then we can confidently institute nasal decompression and slowly and carefully get the patient into the best of shape by relief of dehydration and ion loss.

This point is to my mind of great importance and will stand repetition. In the presence of tenderness or rigidity do not wait for decompression or fluid administration but operate at once for fear of gangrene.

The most important symptoms, as beautifully described by Doctor West, are intermittent colicky pains associated with constipation. The increase in peristaltic sounds as the pains increase is typical but not always present. The white blood count has never been of help to me. In regard to low blood chlorides it is well to remember that such a finding is in no wise a symptom of obstruction but an index of vomiting with its associated fluid and ion loss.

I am happy to see that Doctor West does not depend upon the x-ray for his diagnosis. I believe entirely too much faith is placed in the x-ray and too often the physician depends upon the x-ray man to diagnose his case. My greatest help from the x-ray comes in differentiating small from large bowel obstruction and in watching the progress of nasal decompression. I would like to mention here that I do not believe decompression in the large gut can be done, and should never be attempted.

I strongly agree with Doctor West in his quotation from Moynihan that "an irrefutable diagnosis is desirable but unimportant." I have seen too many patients die because their physicians were not sure they had obstruction. We must operate if obstruction is suspected, certainly so, in the presence of tenderness.

Nasal tube decompression, either by the simple suction or double lumen tube, is saving lives that would formerly have been lost. And, too, their prolonged use is causing preventable deaths.

How beautiful in a case of late simple obstruction to watch complete decompression with the Abbot-Miller tube. How much simpler the operation. But please let us remember that in attempting decompression we must carefully study the patient with frequent x-ray pictures and at any time if decompression ceases to progress, then surgery is immediately indicated. An enterostomy at the site of obstruction will decompress the intestine even when nasal suction has been of no avail.

Intestinal resection in the presence of dilated edematous intestines is an invitation to death and is an inexcusable procedure in these days of nasal tube decompression and safe enterostomies.

Doctor West has given an excellent review of obstruction of the small intestine. It has been a privilege to attempt to stress certain points from so excellent a paper.

*Dr. Frank Gray, Orlando:*

I wish to congratulate Doctor West on his able presentation of a very important subject and to thank him for the privilege of both hearing and discussing this paper.

I agree with all that he has said both as to the treatment and handling of obstruction of the small bowel. Fifteen years ago we saw numbers of patients with intestinal obstruction come into the hospital in a moribund condition, the majority of them dying before operation could be done or immediately postoperatively. This un-

fortunate condition may have been the fault of the patient for delay in calling a physician, or of the attending physician in not recognizing the gravity of the situation. Nevertheless, a number of lives could have been saved had they been offered surgical treatment early in the disease. As Doctor West has stated any patient having acute abdominal pain should be immediately hospitalized and observed closely. Many lives can be saved if this is carried out diligently.

Intestinal intubation as an adjunct to the treatment of intestinal obstruction has been a marked advance in the treatment. Intubation does not, of course, exclude operative means of handling obstructions but rather facilitates any operative procedure. It carries the patient past the period when operation is most dangerous; it prepares him for operation by the control of distention thus cutting down trauma and making it less difficult for the surgeon; it affords a means of localizing the site of the obstruction; it permits oral feeding of the patient during a period when food and fluid are very essential.

Orr recognized a number of years ago the importance of combating dehydration and the replacement of chlorides, lost as a result of dehydration. Falconer of the Mayo Clinic in recent observations has called attention to the importance of the serum bases during intestinal obstruction. He suggests the use of not only sodium chloride but potassium and calcium as well. He also calls to our attention that the blood urea should be checked frequently during the treatment of obstruction as a rise indicates a poor prognosis.

*Dr. Harry A. Peyton, Jacksonville:*

Statistical studies of the mortality and morbidity rates in acute appendicitis and acute intestinal obstruction show that there is still need of improvement. While education of the public is desirable, I suspect that education also is needed at home, *i. e.*, within the profession itself. For this reason it would be well to include in every general medical program a full and free discussion of these two important subjects.

Doctor Stewart's remarks as to the necessity of differentiating the two types of acute intestinal obstruction can not be too strongly emphasized. Failure to recognize that type which is associated with interference with the blood supply, *e. g.*, strangulated hernia, intussusception, volvulus, mesenteric occlusion, etc., leads only to disaster if not operated early. When in doubt as to the type of obstruction, it is much safer to operate than to run the risk of encountering a gangrenous bowel when the patient is in poor condition to stand an extensive operation for resection.

The toxic factor in obstruction has always been a moot subject. Many explanations have been advanced, the most feasible of which has been that some toxic product is formed in the lumen of the bowel. Recent experimental work on dogs by Wangenstein would seem to refute this theory. This investigator has shown that, if swallowed air is obviated by the performance of a cervical esophagostomy and later an obstruction of the terminal ileum is produced, very little distention is found proximal to the obstructive lesion. One conclusion reached was that if swallowed air could be excluded, digestive juice could be absorbed and the obstructive process would be tolerated fairly well. In practice, this is accomplished by stomach or intestinal intubation with suction. Wangenstein further concludes that the toxic factor is a mechanical one due to intraluminal distention, which interferes with blood supply to the bowel wall with consequent decreased viability and increased permeability. From this reasoning it would appear that such abnormal absorption in the presence of a damaged gut wall might very well be by the transperitoneal route. If these deductions are correct, and it seems entirely reasonable that they are, the rationale for the use of suction drainage of the obstructed bowel can be better appreciated.



*Dr. Hugh West (Concluding):*

Of course, the Miller tube is particularly indicated for these rather late cases.

The most important thing is laboratory study and proper evaluation of the clinical signs. A definite clinical diagnosis is desirable but not really important.

I wish to thank Dr. Stewart, Dr. Gray and Dr. Peyton for their discussions of my paper.

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YELLOW JACK

GEORGE N. MACDONELL, M.D.

Miami

Yellow jack, almost forgotten, has staged a comeback. He is reappearing in the literature, he has made the movies, and he is occupying a prominent place in the minds of thoughtful public health officers and sanitarians.

It is very appropriate that as medical practitioners we review the symptoms of what is, to most, only a textbook disease. We, who are located at one of the most vulnerable spots in the United States for the introduction of yellow fever, should post ourselves on the symptoms of a disease we may one day be called upon to diagnose and treat.

The onset is sudden, with frontal headache, pain in the back and limbs, accompanied by prostration. The temperature rises abruptly to between 102 F and 104 F. A remission may occur on the second or third day, when the temperature again ascends to the original elevation or higher. In mild cases it reaches normal about the fifth or sixth day, but in severe cases may remain elevated for a week or more. In fatal cases it may drop to normal twelve to twenty-four hours before death, which may occur as early as the fourth, or as late as the tenth day.

The pulse does not follow the temperature, an initial rise to 110 beats dropping on the second or third day to 80 or even lower. This crossing of the pulse and temperature curves, known as Faget's sign, was, in former days, given much consideration as a diagnostic point. Epigastric tenderness usually appears from the second to the fourth day. There is usually anorexia and some photophobia. The liver may be enlarged and tender to pressure. It is rather surprising that this does not always occur, since the liver, together with the spleen and kidneys, is involved in every case.

A careful search may reveal a slight icterus

of the conjunctival membranes as early as the third day. In most cases the sclerae, the floor of the mouth and the skin take on the yellow hue which gives this disease its distinctive name. Perhaps the most characteristic sign and the one of most value from a diagnostic standpoint is albuminuria which usually begins about the third day. In yellow fever there is an acute parenchymatous nephritis more or less severe. It is little short of marvelous that such severe damage to the kidneys, as well as to the liver, leaves no appreciable sequelae in those who recover.

In fatal cases there is an anuria which, occurring at the time when the liver function is impaired and myocardial involvement is commencing, tips the scales against a possible recovery.

Nausea and vomiting are a rather constant symptom, the vomitus being bile stained. It may be grumous, the dreaded "vomito negro" or black vomit being evidence that extensive extravasation of blood from the capillaries of the lining of the stomach has occurred. The gums and sometimes the conjunctivae ooze blood. The blood picture is not characteristic. There may be a mild leukocytosis during the first day or two, followed by a leukopenia. Serological tests have been disappointing. It is unquestionably a virus disease.

Prostration is great and recovery is slow. The skin may show an icteric hue for weeks in severe cases. The mortality ranges from 20 to 35 per cent. Characteristic lesions are found in the liver and these give valuable and conclusive proof upon the autopsy of fatal cases.

The study of yellow fever may be divided into a discussion of the phases it assumed in three distinct eras. These may properly be designated as the periods of fear, confidence, and uncertainty.

The first period covers the time up to the verification of the theory enunciated by Dr. Carlos Finlay of Havana that the vector of yellow fever is the mosquito, a theory definitely proved with regard to the *Aedes aegypti*, then called the *Stegomyia* by Reed, Carrol, Lazear and Agramonte in their classical experiments conducted at Camp Columbia in Cuba in 1900.

The second period was characterized by the ridding of Havana, Panama and the sea-

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Director of Public Health, City of Miami.  
Read before the Dade County Medical Society,  
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port cities of South America of yellow fever and the prompt stamping out of sporadic outbreaks by the means of *Aedes aegypti* control. This was the era of confidence when we felt sure that yellow fever was definitely and rapidly being relegated to the list of conquered diseases.

The last period may be said to have commenced in 1932, when yellow fever, without the presence of the *Aedes aegypti* was found in Brazil and Bolivia. This led to the discovery that the jungle yellow fever occurring in an immense area in South America must be considered as a permanent source of the virus from which cities and towns with high incidence of *Aedes aegypti* can readily become infected.

Prior to the discovery of the mode of transmission of yellow fever by mosquitoes, the seaport cities of the South lived in a state of suspense every summer fearing the introduction of yellow fever. When it did strike, terror gripped the inhabitants and panic ensued. Rigid measures of control, including shotgun quarantines, fumigation of baggage and even of letters, precipitate burying of the dead, and demoralization of commerce reigned. The epidemic would invariably terminate when cool weather came, it being held that the first frost killed the miasma. We now know that its cessation resulted from the mosquitoes being killed by low temperatures, or at least becoming inactive.

My first encounter with yellow fever was when, as a small boy, my mother and I were visiting in Savannah at the time of an outbreak of yellow fever. My father rushed to the city before the quarantine was instituted and carried us to our home in Macon. Even there, terror reigned when a railroad conductor who had contracted it on the coast died in the house next door to us. Why it did not spread was a mystery then, but is perfectly clear now, since he was not brought to Macon until after the first three and one-half days of his illness, the time when a mosquito biting him could become infected and further transmit the disease.

The fear of the unknown was strikingly illustrated by the measures taken to check an epidemic of yellow fever in Jacksonville in the late eighties. The artillery company was called out and fired salvos in the streets and parks on the supposition that the reverberation

would somehow dispel the miasma thought to be the cause of the epidemic. Such activity seems ludicrous now, but we must remember they were fighting an unknown and unseen foe and the miasma theory of malaria had not then been disproved.

I arrived in Cuba the last day of 1898, which was also the last day of Spanish rule. Two days later I visited an American who was ill in the Hotel Pasaje where I was stopping. Imagine my surprise when three days later he was carried out dead with yellow fever. I had some uncomfortable days and thought it strange when I did not come down with the fever. I was further exposed to it several times, but it was not until ten months later that an infected mosquito bit me and I contracted the disease. I recall how Dr. William Crawford Gorgas, who attended me, after diagnosing my case, remarked: "Well, this is a good one on General Ludlow. Here is a young man of good moral habits, living on the third floor fronting the Central Park, down with yellow fever." General Ludlow, the Military Governor, had been insisting that only those Americans who frequented the low dives on the bay front could contract it. The next day the Yellow Fever Commission, headed by Dr. Carlos Finlay, visited me and confirmed the diagnosis. One of my prized possessions is a certificate of diagnosis signed by Doctor Finlay, President of the Commission, which passed upon all suspect cases.

Through the influence of Doctor Gorgas, I was assigned the following year to serve in the Las Animas Yellow Fever Hospital where I had an opportunity to study the disease in all its phases. One day an American officer came in, introduced himself as Major Agramonte, and asked me to point out a case just admitted. I pointed to a cot on which lay a Spaniard who had just been diagnosed by the Commission. Major Agramonte took from his pocket a test tube and after allowing a mosquito to gorge herself from the patient's ankle, replaced it in his pocket. Out of curiosity, I said: "Major, pardon me, but may I ask what you are doing?" He replied: "We are carrying on some experiments at Camp Columbia to determine how yellow fever is conveyed." Those of you who have seen the movie called "Yellow Jack" will recall a similar scene. This picture, by the way, is one of remarkable historical fidelity. Of the seven leading person-



ages featured in it, I was privileged to know personally four of them: viz., Wood, Gorgas, Finlay and Agramonte.

When the findings of the Reed Commission were announced, I asked Doctor Gorgas what he thought of them. He replied: "MacDonell, I would much prefer to believe that yellow fever, instead of being something in the air which we cannot see, is confined to the body of a mosquito that we can see and can pop." And with that he slapped his hands together with a resounding noise.

Well, it is a matter of history how Gorgas popped the mosquito. In the short space of 15 months, by controlling the breeding of the *Aedes aegypti* and by the screening of yellow fever patients, he rid Havana of yellow fever which, by official records, had been endemic there for 212 years. To this outstanding piece of public health work Miami and southeastern Florida owe their existence as the most attractive tourist section of the nation.

Thus was ushered in the period of confidence. By reducing the incidence of mosquito breeding, Gorgas, assisted by Carter and La Prince, made possible the building of the Panama Canal. The epidemics at Laredo, Texas, in 1904 and New Orleans and Pensacola in 1905 were, by these methods, soon controlled. Rio de Janeiro, Santos and other pest holes were eventually cleaned up. Ecuador and Peru, through the work of Henry Hanson and his associates, were made safe. With South American port cities well in hand and thought safe, Gorgas, after the World War, left for Africa to fight yellow fever in what was believed to be its last stronghold. On his way, while in London, he was taken sick and died. Truly, a great and good man left us when William Crawford Gorgas passed away.

It was a distinct shock to public health workers when in 1932 representatives of the Rockefeller Foundation discovered yellow fever without the presence of the *Aedes aegypti* in Valle do Chanaan, Brazil, and in Santa Cruz de la Sierra, Bolivia. Evidently, there was another vector and an undiscovered source. Further research confirmed this view and what is called jungle yellow fever at once assumed a role of major importance. Now, we know that the valleys of the Amazon, the Magdalena and the Orinoco, together with other densely wooded areas of South America

constitute a tremendous reservoir of jungle yellow fever from which can spread to areas where the *Aedes aegypti* abound, the yellow fever we had complacently believed to have been conquered.

In former times yellow fever was introduced into our southern seaports by slow going sailing ships. Now, the development of rapid transportation by means of the aeroplane has tremendously increased the hazard. Aeroplanes are extensively used in transporting passengers from interior jungle towns to seaport cities. From certain of these ports, passengers enter the United States by the Pan American Airways' planes and may reach distant destinations within the *Aedes aegypti* breeding areas well within the six days' incubation period of yellow fever.

Realizing the danger to Miami, to Florida, and the entire Southland, on September 19, 1929, I addressed a letter to Surgeon General Hugh S. Cumming calling attention to the fact that on the following day Col. Charles Lindbergh would fly from Miami, inaugurating regular passenger flying service to South America. I pointed out that this direct communication with South America would greatly increase the possibility of the introduction of yellow fever, that disease being prevalent in certain cities of Brazil at that time.

I received a reply advising me that the Surgeon General was not unmindful of the potential menace and assuring me that the U. S. Public Health Service would adequately protect Miami against the introduction of this and any other quarantinable disease. Not long after this, Dr. T. H. D. Griffiths carried out experiments with regard to the possibility of conveying infected mosquitoes by aeroplanes. Of one hundred tinted mosquitoes liberated in a plane at Cristobal, Canal Zone, twenty-two were gathered from the plane on its arrival in Miami. Although tinted mosquitoes had been used in determining the range of flight of *anopheles* at Ismailia, this test by Griffiths will stand out as a classical experiment in the history of the control of mosquito-borne diseases by aeroplanes.

The evolution of control measures has progressed rapidly. The U. S. Public Health Service now requires the de-insectization of planes by repeated sprayings, the immunization of flying personnel, the taking of temperatures of the passengers from South America and

their surveillance until the period of incubation is passed, provided their destination lies within the *Aedes aegypti* breeding areas of the United States. Over one million people in Brazil have been immunized by giving them the preventive inoculation.

Miami is keenly aware of the danger of yellow fever and is taking every possible precaution against its spread if introduced. We have not forgotten the dengue epidemic of 1934 with 15,000 cases in Greater Miami and that it was due to the presence of *Aedes aegypti* mosquito, the same mosquito that conveys yellow fever. The fact that seventy cities and towns in Florida had secondary epidemics should be a warning to each one of these places that they, too, should be farsighted and plan for a continuous program of *Aedes aegypti* control. A joint program carried out by the U. S. Public Health Service, the State Board of Health, the Dade County Commission and the City of Miami under the supervision of Mr. Fred Stutz is doing excellent work in holding down the incidence of *Aedes aegypti* breeding to safe limits. A few weeks ago eighty-six doctors, nurses and others in Miami were given immunizing inoculations by the U. S. Public Health Service. The number should be greatly increased.

Miami realizes its responsibility by reason of its unique position. If the sand in an hour glass could be made to flow upward it would well represent the actual layout, that part of the United States south of a line drawn roughly from Baltimore through St. Louis to El Paso, Texas, being the upper globe, the upper half of South America the lower globe, with Miami occupying the neck through which passes elements of potential danger. The U. S. Public Health Service, in cooperation with the Department of Public Health of Miami, is saying of yellow jack that so far as they can prevent it, it shall not pass.

We no longer have the feeling of confidence as to yellow fever being under control. A spirit of uncertainty has taken its place. While we regret its resurgence in its new guise and we admit a feeling of dread as to its possible spread to this country, we no longer have the blind, unreasoning fear an epidemic always produced. Mosquito eradication and the immunization of individuals give us a dependable method of handling it. But we must not be over-confident. It is the part of wisdom for every community to plan and carry out a pro-

gram of mosquito control. Florida and the South should wake up to the danger confronting us.

We must not be alarmed, but we should be alert.

Box 1861.

## CORONARY OCCLUSION IN GENERAL PRACTICE

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My reason for presenting this paper on coronary occlusion is that this pathological process in its various phases necessarily commands the attention of each of us in general practice to a greater extent perhaps than any other single disease. Our attention is too frequently called to the premature passing of one from our own profession, members of which appear to have a particular susceptibility to its grasp. We are entering our winter season and we will again soon have in our midst a great number of winter visitors, the great majority of whom are in the age of the degenerative diseases. Many make their annual visit to our state to take advantage of the mild climate chiefly because of some pre-existing vascular pathology.

I cannot, in the brief time allotted for this presentation, hope to adequately cover the entire subject. If by means of this paper, I can stimulate a discussion whereby we may add to our armamentarium for the prevention, recognition or treatment of this serious disorder, I shall be grateful indeed.

### PATHOLOGICAL CONSIDERATIONS

Coronary occlusion may be produced in one of four ways: arteriosclerotic narrowing of the lumen of coronary artery or arteries; thrombosis; syphilitic aortitis at the root of the aorta which seals the mouth of the coronaries; and embolism by vegetations from an endocarditis, which is rare.

In arteriosclerotic occlusion the process may be a gradual one so that anastomotic systems may develop which will carry on the circulatory load and maintain the nutrition of the heart muscle. There are three chief anastomoses: between the right coronary and the circumflex branch of the left; between the right coronary and the anterior descending

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branch of the left; and between the coronaries and the extra-cardiac branches of the aorta.

#### ANALYSIS OF SYMPTOMS IN TERMS OF THE CLINICAL PATHOLOGY

Several theories have been advanced to account for the production of the symptom of pain. The recent work of Sir Thomas Lewis seems to give the simplest and yet most complete explanation. Lewis found that if the blood supply to a part, as the arm, was suddenly cut off and that the muscles of the hand were continued in motion, an excruciating pain would be produced almost at once which would continue until the tourniquet was released, even though the muscular activity was stopped. His theory is, then, that due to the muscular activity, chemical substances are produced in the muscle which accumulate in the tissues, and by their presence produce pain. I might suggest to you that on returning to your office you wrap the sleeve of your sphygmomanometer to your arm, and pump up well above the systolic level, then exercise your hand for thirty seconds. In coronary occlusion the heart muscle is forced to carry on in spite of the pain and ischemia, and hence the long and excruciating pain. Another theory is that the heart muscle goes into a painful spasm when the blood supply is cut off. Other observers believe that the cardiac pain is due to overdistention of thin-walled coronary arteries and that the pain originates in the afferent sympathetic nerve endings in the wall of the coronary arteries. It will readily be seen that thrombosis of a small coronary artery will cause overfilling of the portion proximal to the infarct. In occlusion of larger vessels there is a loss of contractile power of the myocardium with overdistention of the coronaries resulting. In instances of coronary occlusion, or where infarction takes place without pain, it appears that the desensitization of nerve and muscle fibers has taken place by a process of slow occlusion and as a result of old scar formation there is no longer the pain response.

The leukocytosis which accompanies coronary artery occlusion is due to the formation of what might be considered an aseptic abscess in the infarcted area. At first there is the formation of the white infarct which is surrounded by a red zone. There is usually a firm consistency which in large infarctions may soften and break down into hemorrhagic

granular areas. In such instances rupture of the heart may occur. If the infarction extends through to the endocardial surface, emboli are more likely to arise. If the patient survives the attack for some time the dead muscle is gradually replaced first by soft granulation tissue and later by actual scar tissue. Small scars may cause little or no future difficulty or they may result in permanent muscular insufficiency and even to aneurysmal formation.

Fever in occlusion is a very interesting phenomenon. It is due to a febrile necrosis in the myocardium. A difference of four to five degrees may exist between the oral and the rectal temperature. There is evidently a heat loss over the head, neck and chest due to the state of collapse and shock, which loss is not felt in the pelvis.

#### THE CLINICAL PICTURE

While pain may be entirely absent, it is the chief symptom of the disease. Very frequently the patient is awakened at night with severe discomfort in the chest and pain which varies from moderately severe to excruciating. The location of the pain is variable but most often over the precordium or upper epigastrium. It is usually the pain of a heavy pressure or a squeezing sensation. Duration of the pain is likewise variable, lasting from an hour to even 24 to 48 hours. Frequently it will subside only to recur in a few hours.

Fear of impending death is an accompaniment of the pain. There is great weakness. Shock is present in varying degrees and at times is very severe. The blood pressure may be elevated for the first few hours but it almost invariably falls after a few hours if it has not done so at the onset.

To my mind the most aggravating symptom after relief of pain is nausea and vomiting when present. It is distressing, indeed, to have a patient continue to vomit with the accompanying muscular activity and movement necessary to complete the act, and all the while you are afraid that any movement may occasion further occlusion and possibly death.

The physical findings on examination of the heart are perhaps the most variable of all. Usually there is acceleration of the rate but there may be no increase. Almost any disturbance of rhythm may be superimposed and auricular fibrillation is the most common. Ventricular tachycardia is a frequent accom-

paniment. Perhaps the most significant diagnostic sign is the pericardial friction rub, but when this is present it is transient and may easily be missed.

Dyspnea may be very severe and may be the chief symptom for which the patient seeks relief instead of the usual pain. The urinary symptoms are variable and there frequently is a marked oliguria.

Time will permit me to mention only the most usual complications. The occlusion may precipitate a congestive heart failure. Any of the various irregularities may be superimposed, including complete heart block. Rupture of the heart may occur but usually this would not happen for several days after the original infarction. If an aneurysmal weakening be present before the occlusion it may rupture at any time. Emboli are a frequent complication and they may produce hemiplegia, pulmonary, renal, mesenteric or splenic infarcts or even gangrene of an extremity. The patient may die at any time. If death occurs early in the attack it usually results from ventricular fibrillation or shock. Later it may result from any of the complications mentioned. Evidence of a cerebral embolism in the presence of a low blood pressure should warrant a careful study of the heart for evidence of a coronary thrombosis.

#### DIFFERENTIAL DIAGNOSIS

In a hasty review of the differential diagnosis, I wish to mention gallbladder colic. So many of these patients give a history simulating that of gallbladder pathology and if, added to this, the pain may center in the region of this organ, a differential diagnosis may be impossible unless the aid of the electrocardiogram will solve the problem. The attack may resemble any of the acute surgical conditions of the upper abdomen. Then, too, it must be remembered that such surgical emergencies may exist concomitantly with evidence of acute heart pathology. Pulmonary conditions, embolism, infarction, pneumonia or complete pneumothorax may be confused. In a known diabetic, acidosis and coma may be wrongly diagnosed unless the blood sugar is known, and it is to be remembered that insulin can be very harmful to patients with coronary disease.

Of the heart conditions which may be confused, dissecting aneurysm and angina pectoris require special mention. In the latter, dif-

ferentiation may at times be accomplished only after a period of careful observation and repeated electrocardiograms.

#### ELECTROCARDIOGRAPHY

The electrocardiogram, like the symptoms and physical findings, is highly variable. Due to the injury currents at the margin of the infarct and the impairment of electrical conduction, disturbance of balance of the electrical potential results, and is reflected in the electrocardiogram. Whereas, before a cardiac infarction the configuration of the electrocardiogram is more or less fixed, after infarction there are usually a series of changes due to the continually changing balance of electrical forces in the myocardium. Consequently, it is impossible to set up any rule or rules for electrocardiographic changes. It is best to watch for evolutionary changes from day to day. It should be emphasized that the electrocardiogram can only supplement clinical findings.

I shall only enumerate the cardiographic signs which are considered characteristic: (1) RS-T interval deviations; (2) certain characteristic changes in the QRS complex; (3) the so-called "coronary T wave"; (4) huge T waves; and (5) changes occurring in the ventricular complex from day to day. As long as changes continue to be manifested in the cardiogram, it is best to consider that the lesion has not entirely healed.

#### PROGNOSIS

With the present increasing accuracy of diagnosis, the mortality rate for the acute attack in large series of cases reported has dropped from 50 per cent to between 15 and 25 per cent. It will be understood that increasing accuracy of diagnostic methods allows for recognition of many mild cases which heretofore were not considered occlusion.

While the average length of life for the patient surviving the acute attack is but two years, still many do live and enjoy comparatively good health for many years. Certainly, then, the prognosis while necessarily guarded need not be without hope, even in the severe cases.

#### TREATMENT

In the consideration of the treatment of coronary occlusion I shall attempt to consider three phases: first, a consideration of its pre-



vention; second, the care of the acute attack and its accompanying complications; and third, the convalescent period. From the standpoint of prevention, very little can be offered, as this disease is essentially one associated with and a complication of arteriosclerosis. We would instruct our patients suffering from this latter disease to direct their lives in as pleasant channels as possible, to avoid excesses of a physical or mental nature, and where possible to avoid too quick returns to full activity after acute diseases. In passing, we might mention the observations of Leary with reference to the disturbance of cholesterol metabolism, but we cannot feel that any form of dieting is rationally indicated.

As we know that diabetes plays an important role in the development of arteriosclerosis and coronary occlusion, it would be best to emphasize the importance of a proper control of our diabetic patients and particularly to see that adequate sugar is present in a usable form for the proper nourishment of the heart muscle.

The sheet anchor in the treatment of the acute attack is, of course, morphine. Its use should be liberal; and in the severe attack, it is my opinion that the first injection should be given intravenously. Too often do we find on administering a large intramuscular dose that the patient does not get relief in the time usually required for the relief of pain of that severity. I believe this failure to get relief is frequently due to the impaired circulation which would necessitate a slow absorption of the opiate. While it is recommended by some, I have never had the courage to give one of these patients a whiff of ether or chloroform.

It has been my practice to administer a hypnotic as early as possible, in order that the fear of impending death, which so frequently accompanies the attack, may be relieved. For the relief of the very annoying nausea and vomiting, I on one occasion carefully introduced a Levin tube through the nasal passages and into the stomach and following aspiration and gentle lavage there was prompt relief. This also provides means of administering an amount of saline or glucose solution to replace the water loss from the profuse sweating and vomiting. If additional fluid is needed it should be given subcutaneously. There are some that recommend intravenous

administration of 50 per cent glucose in small quantities.

Oxygen when available is of great importance for the relief of dyspnea. As to what method is used in its administration I do not feel that it matters as long as sufficient oxygen is available at all times. It is a relief measure for which the patient is most grateful.

If there is evidence of the development of heart block, adrenalin is indicated and may be life-saving. It may be required every few hours for the first forty-eight hours.

If there is an onset of paroxysmal ventricular tachycardia, quinidine must be administered, as it is the only drug which will control this irregularity. It should be given in quantities sufficient to stop the attack, and this will vary from five grains to twenty grains, and may need to be repeated at three or four-hour intervals to prevent the return of the tachycardia. Digitalis, if given at all, should be used guardedly. If there is persistent auricular fibrillation, it should be given, or in any case where there is evidence of congestive heart failure or broken compensation as evidenced by peripheral edema, engorged liver or hydrothorax.

As to the use of such drugs as aminophylline during the acute attack for its effect as a coronary dilator, it is difficult to estimate their value; and in the absence of further evidence to contraindicate their use, it is impossible to pass judgment on their efficacy.

The patient should be put at absolute rest. If his attack occurs away from home, he should immediately be sent to home or hospital by ambulance; he should not be allowed to move from one room to another except by stretcher, and then only if necessary. External heat should be applied to aid in combating the shock. He should not be disturbed by relatives, but should be attended by an adequate number of well-trained nurses to insure his care every minute of the day. A physician will find it to his advantage to spend as much time close to his bedside as possible, as too frequently when we are called away it is to find our patient dead when we return. Of course, it is not always possible to have nurses and other arrangements so necessary, but when it is possible it is well worth the effort.

A low caloric diet is recommended for the first few days following the attack.

The convalescent patient should remain in bed at absolute rest for a minimum of six weeks. After the period of bed rest, he should take at least two weeks in the process of getting out of bed; and the return to his usual activities must necessarily be slow and a matter of months, depending upon the evidence of heart damage resulting.

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## CLINICAL ENDOCRINOLOGY OF THE MALE

WITH ESPECIAL REFERENCE TO THE  
MALE CLIMACTERIC

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### THE DUCTLESS GLANDS IN THE MALE

It is generally agreed that the first known facts in endocrinology are the effects of castration on the male slave eunuchs of the oriental potentates centuries ago. That fact notwithstanding, the most remarkable advances in endocrinology have been heretofore generally connected with the endocrine system of the female and very few attempts have been made to study the particular male endocrinological picture in general.

As it is impossible in the time allotted for this communication to make even a mere resume of all the peculiarities of the endocrine system characteristic to the male sex, I am going to try to bring to your attention only a few of the many facts involved in the sexual physiological and psychological development of man, especially those having a particular relationship to the establishment of the climacteric syndrome.

### THE PITUITARY HORMONES

About fifteen hormones have been identified with the pituitary gland.<sup>5, 17, 19, 20</sup>

The anterior lobe produces most of them: the growth hormone from the acidophile cells and the sex or gonadotropic hormone from the basophile cells are the best known of the anterior pituitary hormones. Others are the thyrotropic, adrenotropic, lactogenic or prolactin, diabetogenic or hyperglycemic which is antagonistic to insulin; pancreatropic or contrainsulin hormone, stimulator of the islands of Langerhans and parathyrotropic hormone.

The posterior lobe has been credited with pitocin or uterine contractor and pitressin or vasopressor hormone, also controlling water metabolism and gastro-intestinal secretions. The pars intermedia produces intermedin, regulator of pigmentation.

A fat metabolism hormone, a nitrogen metabolism hormone, a melanophoric, an erythropoietic hormone and others have been tentatively identified in extracts of either anterior or posterior lobe, but are not yet well known.

The growth hormone and the gonadotropic hormones take important part in male sexual development. They are antagonistic with each other, but their effects take place successively and in that way they complement each other. The growth hormone is mostly produced in the earlier periods of life up to adolescence, when the growth of the body must be carried on at its highest intensity. With the onset of puberty and development of the genitalia, together with onset of full activity of the gonadotropic and gonadal hormones, growth becomes slower and with the establishment of the reproductive functions in full swing, the growth function finally decreases. As age advances, the number, size and activity of the eosinophile cells of the pituitary decrease to a minimum, when the growth hormone is no longer necessary in amounts as large as in youth.<sup>5, 20</sup>

The gonadotropic hormone produced by the basophile cells is really a complex of two principles:<sup>7</sup> prolactin A, follicle ripening factor in the female or spermatogenic factor in the male and prolactin B, luteinizing factor or masculinizing factor.<sup>8</sup> Prolactin A stimulates in the male the germinal epithelium of the seminiferous tubules with the production of spermatozoa and, indirectly, through the testicular hormones it stimulates also the growth of the prostate and seminal vesicles.<sup>9</sup>

Prolactin B in the male stimulates mainly the interstitial tissue of the testes and produces important effects by way of the testicular hormones, determining the increase in size during fetal life of the penis, scrotum, cord and inguinal canal to produce the descent of the testicles and further on in life it is instrumental in the development of the male secondary sex characteristics.

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#### MALE PITUITARY HORMONAL DISTURBANCES

A disturbance in the production of growth hormone is manifested by abnormalities in the bones, muscles and other parts of the system. If there is a deficiency in the secretion during the growing periods of life, growth is stunted with the production of dwarfism in several varieties. An excess in growth hormone during childhood will produce exaggerated growth of the long bones and if maintained for long before the epiphyses are closed, will result in gigantism. After closure of the epiphyseal lines is complete, an excess of growth hormone results in acromegaly. Sometimes both pictures are superimposed in the case of acromegalic giants.

Both gigantism and acromegaly have a predominance for the male sex<sup>20</sup> and in both syndromes there is marked hyperpituitarism in the first stages, manifested by increased growth and muscular strength, early sexual maturity, decreased sugar tolerance, glycosuria and hyperglycemia frequently carrying into diabetes and also frequently polyphagia, polydipsia and polyuria as manifestations of diencephalic involvement due to pressure from a pituitary gland more or less considerably enlarged, either by simple hypertrophy, or by the formation of an adenoma of the eosinophile cells.

During its late stages, hyperpituitarism gives place to a completely opposite picture due to the destruction of the pituitary cells, with increasing mental, physical and sexual degeneration and the end comes usually early in life by asthenia due to adrenal involvement, by intercurrent infection, by cardiac disorders or by pituitary cachexia.

Hypersecretion of the gonadotropic hormone causes precocious development of the gonads with marked enlargement of the prostate, seminal vesicles and Cowper's glands. In some cases, a pluriglandular syndrome may be produced by primary overfunction of the pituitary basophile cells, characterized by plethoric obesity of the middle of the body, hypertension, disturbances of pigmentation, hypertrichosis and hypergonadism in the young and gonadal degeneration associated with progressive weakness, headache and glycosuria in the adult. Cushing attributed this syndrome to the pituitary adenoma of

the basophile cells and named it pituitary basophilism.

Insufficiency of the gonadotropic hormone, if it occurs in childhood causes sexual infantilism by lack of stimulation of the gonadal hormone and, if in the adult, it results in a regression from the state of sexual development previously attained. In all cases, a lack of the gonadotropic hormone contributes to frigidity and impotence and to deficient development of the genitalia and of the characteristic male evolution of the body.

There are several syndromes identified with hypopituitarism in the male: thyropituitary infantilism, usually associated with mental retardation and obesity; pituitary eunuchoidism with slight predominance of growth, tall stature and underdeveloped genitalia, adiposogenital or Frölich's syndrome in which a characteristic obesity, gynecomastia and arrested sexual development accompany a normally developed mind, occasionally a genius; somatic type of dwarfism or Lorraine-Levi type, and many others that we have no time to mention.

#### THE GONADS

Like the ovaries, the testicles have both external and internal secretion. The former is spermatozoa and some of the suspending fluid produced in the seminiferous tubules. The internal secretion is produced by certain cells situated in the connective stroma of the testes. These cells, first described by Leydig in 1850 without knowledge of their function, are known today to exert through their secretion of the male sex hormone, a decisive influence upon the maturation of the skeleton and skeletal muscles, the ossification of the epiphyseal lines; the development of the larynx into the adult male type with large vocal cords capable of emitting the low-toned voice of man; and over the male type of hair and fat distribution on the body.<sup>1</sup> They also contribute vitally to the development of the penis, scrotum, testes and seminal vesicles, assist in spermatogenesis and genital function, and create and maintain libido and sexual power; in other words, they regulate directly the whole male sexual physiology and, indirectly, the male psychology and social reactions.

The Leydig cells function under the im-

pulse of the gonadotropic pituitary hormone<sup>1</sup> and their secretion of male sex hormone inhibits and regulates the secretion of the anterior pituitary gonadotropic factor. Another necessary stimulator to male hormone secretion comes from the adrenal glands which, if removed, result in testicular atrophy.

#### THE MALE SEX HORMONES

There are three main forms of male gonadal hormone, in analogy with the three forms of estrogenic substance of the female organism. They have all been obtained in crystalline form soluble in oil, and are now chemically synthesized:<sup>1-6</sup> (1) testosterone has been obtained from the testicle; (2) androsterone and (3) dehydro-androsterone are both excretion products obtained from male urine and very much less potent than testosterone. All receive the common generic name of Androgens in opposition to the female Estrogens. Androkinin and Androcin are less commonly used terms.

A water soluble factor, allegedly responsible for the inhibitory action upon the anterior pituitary lobe is called inhibin and its injection into castrated male rats prevents the formation in their pituitaries of castration cells.

The excretion of androgens starts shortly before puberty as indication of the approaching sexual maturation under the gonadotropic stimulus of the pituitary. It increases gradually until in the adult male the daily output has been estimated at from 40 to 50 international units daily.<sup>20</sup> Its production is influenced by vitamins A and E and is definitely increased by ultraviolet irradiation, particularly over the skin of the genital region.<sup>9</sup> Between the ages of 40 and 60 the production of male sex hormone decreases gradually and in old age it is reduced to minimal amounts, but rarely disappears completely.

Chemically the androgens and the estrogens are intimately related to cholesterol from which they are prepared synthetically by degradation.<sup>8</sup> They are probably slight chemical variations of the same fundamental substance and show imbricated and similar effects in both sexes. Also both hormones, or at least their excretion forms, are found in the urine of both men and women. In the female

the secretion of androgens has been estimated at from 25 to 40 international units daily, while the estrogenic substance is found from 40 to 60 units. And in the male, estrogens are excreted up to from 20 to 40 units daily.<sup>20</sup>

The normal predominance of the respective hormone in each sex determines the characteristic orientations in both the physiological and psychical spheres, peculiar to the types of the ideal male and female.

#### DEVELOPMENTAL ABNORMALITIES AND FUNCTIONAL DISTURBANCES OF THE GONADS

In eunuchism there is total absence of the testes and in eunuchoidism the testicular secretion is deficient resulting in important somatic, physiological and psychical changes ranging from mild cases with deficient sexual power, low metabolism and general physiologic slowing, to those in which there are characteristic antropometric measurements with decrease or total lack of development of the secondary sex characteristics if occurring before maturity has been attained, or with their regression if occurring in adulthood.

These patients share a common low resistance to infection<sup>13</sup> and high allergic sensitiveness which makes them chronic sufferers of colds, dermatitis, asthma, etc., and their span of life is usually shorter than the average.

Obesity of the girdle type is a frequent complication.<sup>2, 5, 14, 17, 18, 19, 20</sup> Others are: dementia praecox, homosexuality, cirrhosis of the liver, malignancy, diabetes, and other endocrine disorders.<sup>5</sup>

Cryptorchidism is the failure of the testes to descend to the scrotal sac, due to a lack of endocrine stimulus from the pituitary, usually together with congenital abnormalities of the inguinal canal, the gubernaculum, or the testicle itself. Cryptorchidism usually accompanies hypogonadism. The testicles usually do not suffer degenerative changes before puberty and frequently descend spontaneously at or before that time but, if retained in the abdomen after puberty, the spermatogenic tissue undergoes degeneration with loss of function and they also become more prone to malignant degenerations and tumors.

Hermaphroditism is really only the exaggeration of the fact that both male and female characteristics are, from the hormonal point



of view, present in all individuals.<sup>8</sup> True hermaphroditism, in which functioning generative organs of both sexes would be present in the same individual, has very rarely been demonstrated. Pseudohermaphroditism may be in a male in which malformation, atrophy or malposition of the penis, scrotum and testes resemble superficially the female genitalia, usually with accompanying gynecomastia and the feminine traits of character, and it may occur in the female in which an enlargement of the clitoris, rudimentary vagina and labia and hirsutism, low pitched voice and typically male psychological tendencies are apparent.

Hyperfunction of the testes with hypersexualism in a pathological degree is rarely found except in the presence of tumors, either of the basophilic cells of the pituitary, or of the adrenal cortex or the pineal gland, or of the testicle itself.<sup>11</sup> The latter are usually malignant, either seminoma of the sarcoma type or teratoma, very malignant tumor involving cells from all three germinal layers.

The usual attraction between the normal individuals of opposite sexes is caused by the predominance of their respective sex hormones.<sup>6</sup> In homosexuals, a reversal of the usual balance has been consistently found by several authors. In the male, a comparatively high estrogenic with low androgenic excretion in the urine, parallel the opposite picture in the female homosexual. Thus, according to Wright,<sup>12</sup> "sex attraction of the homosexual is as physiologically logical in relation to his hormone balance, as that seen in normal individuals. . . The fact that these abnormal tendencies frequently begin in youth or puberty, would in itself indicate an endocrine etiology."

It also suggests an endocrine treatment of these unfortunates by the administration of the sex stimulating hormones of the anterior pituitary lobe and of suprarenal cortex hormone, both with the purpose of enhancing the sex characteristics of the individual and restoring his normal hormonal balance.<sup>9</sup>

#### CLIMACTERIC CHANGES IN THE MALE

We have seen how the secretion of the interstitial cells of Leydig, or male sex hormone, is directly responsible for the de-

velopment in the boy of his secondary sex characteristics. We know that androgens are not secreted in appreciable amounts before puberty, but at a time just preceding sexual maturation its secretion and excretion reach a maximum which is in direct relationship with both the sexual activity and psychic and physiological functions.<sup>20</sup>

The production of testosterone follows a parabolic curve with its ascent started between the ages of 10 and 14, and continued gradually up to the age of 22 or 25. It then remains almost at the same level for from 5 to 10 years, and starts a gradual decline, almost insensible at first, at the ages of 32 to 35. This decline will be rapidly accentuated between 40 and 50, and at the age of 55 to 60, in most men, the activity of the Leydig cells is about the same as that before puberty.<sup>17</sup> The number of the cells themselves is known to decrease in the interstitial tissue along with the passing of the years, and in old age there is a reversal to a state similar to that of early childhood, with the Leydig cells reduced to a minimum in the senile atrophied testicles.<sup>5</sup>

We see, thus, how the periods of life when the male human machine is at its best, are those in which the stimulus of the male sex hormone is at its maximum. We know that the peculiar aggressiveness, the creating power and, in general, the capacity for success in an individual are directly dependent upon the secretion of his own sex hormone.

When the decline in the number of Leydig cells begins at the age of 40, more or less, the individual has passed his peak and begins the inevitable descent. This descent is normally so gradual that the individual has plenty of time to get the necessary resignation without too serious mental and physiological derangements. But though gradual, the descent is continuous and we can observe the gradual undoing of all the products of gonadal stimulation during the puberal period. Any one of the following may announce the process: (1) The sexual powers diminish and the penis and testes start to undergo slow, gradual atrophy after losing their younger turgescence, and although the production of spermatozoa may be maintained for a very long period of time,<sup>18</sup> the decreased libido and potency make their utilization for generative pur-

poses a matter of exceptional rarity. The prostate, on the contrary, usually starts a process of fibrous hypertrophy at about 40, in some cases slowly, in others rapidly, reaching a large size and interfering with the free elimination of urine, facilitating infection of the bladder and obstructive toxic phenomena. (2) The hair begins to lose its pigment and in many cases begins early to fall, never to return, thinning gradually in head and body until the characteristic scantiness of senectud. (3) The skeleton and skeletal muscles start losing some of their hardness and strength, fractures are slower to heal and a definite shortening of stature is established. (4) The larynx, that had enlarged by the specific action of testosterone, with characteristic change in the vocal range from the high pitched voice of childhood to the deeper tones of adulthood, first relaxes with a change to a still lower basso and then atrophies changing the voice to the typical crackling of senility. (5) The distribution of fat over the body is frequently affected by increased deposits, especially over the abdomen, face, shoulders and buttocks. (6) Finally, the masculine psychological pattern and attitude undergo changes that make this picture of the male climacterium a very interesting one in many aspects.

In women, the psychological changes of the menopause are very well known. The irritability and susceptibility of the woman past middle age have been the subject of innumerable scientific and literary contributions and in Spanish it has received a name accepted even in medical literature which translated means "mother-in-law complex."

In men, these changes have been for many years obscured by the importance given to the natural accompanying degenerative changes of the system resulting in arteriosclerosis, myocardial and coronary diseases, hypertension and the innumerable types of gastro-intestinal neurosis, manifestations most of them in my opinion, of the neurovegetative changes brought about by the decline in sex hormone production.

The practical demonstration of this theory lies in the proved ability of testosterone to relieve most of these symptoms for a more or less prolonged period of time in most instances. I am not claiming that testosterone could cure arteriosclerosis or coronary disease

or gastric ulcer, but I am positive that in many cases it can slow those processes and delay their fatal outcome for a certain time at least.

We have seen time and again how menopausal hypertension subsides in many women with the administration of estrogenic substances. The same thing happens in many cases of hypertension in males past middle age after several injections of testosterone propionate. And we could go on in the same manner over each one of the elements composing the climacteric picture of man.<sup>1</sup> Brown-Sequard was the first one to show, by injecting himself at the age of 72 with testicular extracts, the invigorating effect of the Leydig cells secretion upon the waning forces of the body and of the mind.<sup>5, 20</sup>

Steinach of Vienna proved less than twenty years ago that by vasoligation or vasectomy in both animals and humans a reactivation of the Leydig cells bring about renewed sexual vigor and potency, disappearance of wrinkles from the face, increase in mental and physical powers, decrease in graying of hair, etc.

Kammerer also of Vienna, reported shortly afterwards how mild doses of x-rays to the ovaries and testes, sufficient to destroy the parenchyma, would produce the same effects as the Steinach operation and Doppler's modifications, by reactivating the interstitial tissues bringing rejuvenation in both women and men.

We still remember also the attempts of Voronoff and his occasionally astounding results after transplanting testes from chimpanzees into a pocket in the abdominal skin. Although in most cases the implant has not taken or has been absorbed rapidly, in others the results of rejuvenation have lasted for as long as three years.

In all these attempts, the purpose was to increase the production of the male sex hormone. Today we are fortunate enough to be able to handle the synthetic testosterone in a form readily useable and in amounts sufficient for effective substitution therapy in a parallel with the estrogenic therapy in the female.

If we consider, added to the normal climacteric picture in man, the hypogonadism carried on in many instances from childhood or



early adulthood, we might be able to understand how much good can be done by the judicious application of this blessed therapy, as much at least as the relief of suffering, and the peaceful life brought to so many women by the estrogenic therapy in the last few years.

The most active form of the synthetic male hormone is that of the salt of the propionic acid, testosterone propionate, sold commercially under several trade names usually in ampoules containing 5, 10 or 25 milligrams in about one cc. of sesame oil. The effect of these injections in hypogonadism, eunuchoidism and even in castrates,<sup>1, 4, 10, 15</sup> is too well known already; in the hypogonadism of the physiological male climacterium it has been recognized only recently.<sup>8</sup>

In the form of an ointment to be applied by friction on the skin, testosterone seems almost as effective as in injections.<sup>20</sup> The advantages of the lack of necessity of the injections are great, but many patients report a dissatisfaction with the greasy manipulation and the amounts to be given in this manner are necessarily limited. As a maintenance dose, it is very useful after the maximum benefits have been established by several injections.

Proved effects of testosterone propionate therapy in men past 40 are: (1) Definite "lifting" of the usually depressed and melancholic psychics with marked improvement in power of concentration and memory and ability for mental work. (2) As a corollary to that, there is a rapidly established euphoria and renewed ambition with apparent increase in "pep" and general bodily vigor. (3) One of the first nuisances of the male climacteric to respond is the prostatism and nocturia; although definite shrinking of the prostate has not been proved to be the rule, it has occurred in many cases and in the last issue of *Sanidad Militar*, Muxo of Havana, Cuba,<sup>8</sup> reports a group of 25 cases of unselected prostatic hypertrophy treated with testosterone propionate with definite anatomic decrease in size in some of them and a remarkable functional improvement in all. (4) In climacteric men whose testes have not yet suffered too extensive degeneration, sexual powers and libido can be restored in a moderate degree, bring-

ing in many cases peace and renewed marital happiness to them.

To better illustrate the therapeutic effects of this hormone in the climacterium, let me succinctly relate a few cases that I have had the opportunity to observe personally:

CASE 1. G. B., business man aged 40, married, father of 4 children, with a normal sexual history, had noticed for 4 or 5 years, along with the waning of his libido, a decreased ability for the management of his affairs, nervousness, irritability, insomnia and crises of mental depression and of amnesia. Ten mgm. of testosterone propionate 3 times weekly changed his general attitude in about two weeks, with cessation of practically all his symptoms. On a maintenance dose with 5 gm. of ointment containing 2 mgm. per gram of the hormone, rubbed nightly on his skin, he is again enjoying life and his work.

CASE 2. J. L., lawyer, aged 44, monorchid, married for 20 years, had been impotent during the last 7 years. This was a typical case of hypogonadism with early climacterium because of the impaired testicular function. Mental depression and worrying about his condition, together with increased loss of memory, irritability and lack of ambition, forced him to retire at 40 when a lawyer should be at the peak of his career. Obesity of the hypogonadal type, microgenitosomia and hypotrichosis, were marked. Treatment in this case required a low caloric diet and appropriate vitamins A and E surplus, with stimulation of the anterior lobe by prolan injections, and gonadal substitution with male sex hormone. Although sexual potency and libido were very slow to reappear in this case, the improvement in the general well-being, "pep," mental ability and ambition, together with the loss of excess weight were so marked from the beginning, that he has been able to return to his work and he is today again able to support his family. After three months of continuous therapy he can already, at least occasionally, perform his duties in a manner satisfactory to his mate and he feels today happier than he was a year ago.

CASE 3. J. T., a businessman, aged 50, married, father of 3 children, was slightly hypergonadic with history of more than average sexual powers in his youth, hypertrichosis, pituitary basophilic obesity in a mild degree, intermittent glycosuria and mild hyperglycemia for the past 2 or 3 years. He complained of retrosternal pains, general weakness and lack of ambition appearing with the rapid decline of his potentia coendi, gone already for more than two years. In this typical case, the physiological decline produced very intense psychic changes. A very successful man in a business involving hundreds of thousands of dollars, he suddenly gave it up and started to drink. At his first visit he told me that he did not believe he would ever be himself again and that he was anxious to die. Omitting the many interesting details of this case, be it enough to say that under proper psychotherapy, diet and exercise, with testosterone propionate in doses of 25 mgm. daily for a week and on alternate days for three more weeks, he was not only full of energy and ambition again, but able to perform his marital duties once or twice weekly. He, too, reopened his business and carried on a very successful season last year. Today he is kept on a maintenance dose of 10 mgm. of testosterone propionate by skin injection three times weekly, after about 6 months of injections.

CASE 4. B. L., a retired merchant, aged 67, with a normal past history, complained of increasing nocturia and general debility, anorexia and insomnia. His prostate was only moderately enlarged and his residual urine (about two ounces), was free from infection. Injections of 25 mgm. testosterone three times the first week brought gradual but immediate relief of the nocturia. Continued biweekly for three more weeks, he got up only once instead of 8 or 10 times every night,

slept well and had recuperated his appetite and zest for life. He has been kept on 10 mgm. injected weekly for over six months now, without recurrence of his symptoms.

These four cases are typical of some of the most frequent problems presented by the climacteric period in men: early sexual decline with hypertension, arteriosclerosis and melancholic depression; still earlier decline in hypogonadal cases, and the nocturia of benign prostatic hypertrophy.

Of course, glandular hormone therapy, per se, is not all that we have to do for these patients, and general measures of readjustment of life ought to be advised together with proper medication in specific instances, but it is undoubtedly a blessing to man, that just when, because of the advances of the last half century of medical progress, his span of life is being prolonged far beyond the fifties, we can also make those added years happier and more comfortable, creating with this addition to our armamentarium, a new weapon of incalculable possibilities.

#### SUMMARY

Most of the studies made of the endocrine system have been intimately connected with the mechanism of the female glandular system. No attempt has been made heretofore to make a particular study of the endocrine system in the male.

There are many peculiarities of the endocrines that belong to the male. Among the anterior lobe pituitary hormones, the growth hormone is more active and its disturbances very much more frequent in the male. The gonadotropic factors have specific actions regarding the male gonadal functions. Disturbances of these functions produce characteristic pictures in the male, and the deficiency of the androgens in man past middle age brings about a syndrome similar to that of the menopausal woman.

Symptomatic relief and reactivation of general physiology, psychis, and of sex powers

may be attained with the judicious application of substitution male sex hormone therapy.

Four typical clinical histories of the male climacteric are presented.

340 *Ingraham Building.*

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Petersburg, for District 7; Dr. Herman Watson of Lakeland, for District 8; Dr. A. M. Sample of Ft. Pierce, for District 10; and Dr. Kenneth Phillips of Miami, for District 12. The councilors' reports were extremely interesting and indicated satisfactory results from many unusual activities during the year.

Dr. Shaler Richardson, the Association's secretary and treasurer, was then introduced by Doctor Watson, with the request that he outline briefly the financial condition of the Association. Doctor Richardson carefully explained to those present his financial statements published in the Journal following each annual convention. The councilors and other members of the Association made inquiries relative to the Association's means of revenue, items of expense and the amount of surplus accumulated over a period of years. Doctor Richardson's analysis of the financial statements was carefully presented and at the conclusion Doctor Watson extended his thanks for enlightening the councilors and others present, in such an acceptable manner.

The gavel was then returned to Doctor Robinson who presided during the balance of the session. The following chairmen of standing committees were present and made preliminary reports of the activities of their committees, which were of unusual interest and indicated the enormous volume of work directed through the standing committees: Dr. Gilbert S. Osincup of Orlando, Executive; Dr. Walter C. Jones of Miami, Scientific Work; Dr. Horace A. Day of Orlando, Legislation and Public Policy; Dr. J. R. Chappell of Orlando, Medical Education and Hospitals; Dr. J. Ralston Wells of Daytona Beach, Public Relations; Dr. Turner Z. Cason of Jacksonville, Medical Postgraduate Course; Dr. Harrison A. Walker of Miami Beach, Medical Economics; Dr. E. T. Sellers of Jacksonville, Venereal Disease Control; Dr. Edwin C. Swift of Jacksonville, Inter-Relationship; Dr. John E. Maines, Jr., of Gainesville reported for Dr. Ferdinand Richards, Maternal Welfare; Dr. Luther W. Holloway of Jacksonville reported for Dr. Warren W. Quillian, Child Health; Dr. Gordon H. Ira of Jacksonville, Advisory to Woman's Auxiliary; Dr. W. Henry Spiers of Orlando, as secretary pro tem., reported for

## PRE-CONVENTION MEETING

On January 21 the Pre-Convention meeting of the Association was held in Jacksonville at the George Washington hotel. Beginning at 9 a. m., various committees assembled in separate rooms to plan and discuss their committee activities. The Council and a number of the committees were in session the entire forenoon. Just before the luncheon, cocktails were served by the Duval County Medical Society and at 1 p. m. luncheon was served in the ball room, followed immediately by a general session. Dr. Leigh F. Robinson, the Association's president, called the meeting to order and announced the purpose of the meeting.

The gavel was turned over to Dr. Herman Watson, Chairman of the Council, who called for the reading of the annual reports of councilors. Dr. C. C. Webb of Pensacola, councilor for District 1 was unable to be present and his report was read by Dr. Herbert L. Bryans of Pensacola; Dr. B. A. Wilkinson of Tallahassee reported for District 2; Dr. James L. Strange of McIntosh, for District 4; Dr. Robert B. McIver of Jacksonville, for District 5; Dr. George M. Green of Daytona Beach, for District 6; Dr. W. C. McConnell of St.



the General Advisory Board of Past Presidents and stated that Dr. J. Harris Pierpont of Pensacola had been elected chairman of the Board at a meeting in the forenoon. Dr. Meredith Mallory of Orlando made a joint report for himself and Dr. Herbert L. Bryans of Pensacola, the Association's delegates to the A. M. A. House of Delegates. Following the general session, a joint meeting of the Medical Economics, Executive and Public Relations Committees was held to take action on a report handed down from the last meeting of the House of Delegates.

#### REGISTRATION

The total registration during the general session was 50.

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### MEDICAL DIRECTORY, 1940

One free copy of the 1940 Florida Medical Directory will be mailed to each member of the Association the latter part of February. A reproduction of the Basic Science Law may be found among the Medical Laws. Each member is urged to file his Directory carefully for reference. It contains the answers to many questions which arise daily concerning the medical profession.

### CONTROL OF EDUCATION SHOULD SERVE AS WARNING AGAINST STATE MEDICINE

The control of education by the state should serve as a warning rather than as an example of what might be expected under state control of medicine, the Bureau of Medical Economics of the American Medical Association contends in the Association's *Journal* for December 16. The Bureau declares:

By just so much as education does resemble medical service it seems to have suffered under state administration. Only where the contrast is greatest has it been successful.

Standardization in education has not been wholly successful. Forcing teachers and pupils into a common mold is held to be destructive of both individual and social values.

The universal and well-nigh equal need for education has not, under governmental control, kept its distribution, both as to quantity and quality, from varying widely in different localities. In spite of the more uniform character of education compared with medical care, few would claim that our educational system is efficiently administered.

Political influence and pressure groups have worked much harm to education. It is charged that lay supervisors, ignorant of pedagogic methods, hinder professional progress and tend to cripple the freedom of thought and investigation that is of fundamental importance in education. Such influences would be much more destructive in the medical field.

Contrasting certain factors in education with medical service, *The Journal* states:

In childhood and youth every one needs much the same sort of education. Health and illnesses are as individual as human beings. In adult life there are many who wish to learn the same things, so that books, lectures, classes and the radio can be used effectively for mass treatment of their educational needs. Mass diagnosis and treatment of illness breed disaster! Fairly accurate diagnoses of ignorance and of progress through educational treatment may be made by mass examinations.

Ignorance does not appear suddenly or in epidemic form nor does it create an emergency demand for education. The need for education varies only slightly with times and conditions. The positive benefits of education are not confined to the individual. Society realizes a direct return on its investment in the education of its members.

Health and ignorance are alike only in a few features and within those limits the state is already active in both fields.

The state can establish quarantine to protect all the people against the invasion of disease; it can collect and tabulate vital statistics pertaining to the whole population; it can assist in health education, urge wide-spread general immunization and rally the forces to meet the mass attacks of epidemics. Within these and such other limits as have the same qualities and objectives the medical profession has always aided and encouraged state activity.

When individuals are to be aided in the recovery from illness, the analogy of disease with education becomes a contrast. It is seldom that two persons need exactly the same medical care.

Medical service does not fit into time tables or arbitrarily prepared curriculums. It is largely a twenty-four hour service.

## SOUTHEASTERN SURGICAL CONGRESS

The Southeastern Surgical Congress will hold its Eleventh Annual Assembly in Birmingham, March 11, 12, 13, 1940 at the Tutwiler Hotel. The following doctors will present papers and conduct clinics during the Assembly:

Gynecology—Quitman U. Newell, St. Louis; C. J. Andrews, Norfolk; Robert A. Ross, Durham.  
Laryngology—Edward A. Looper, Baltimore.  
Otology—S. S. Hall, Clarksburg, W. Va.  
Ophthalmology—R. O. Rychener, Memphis.  
Medicine—James K. McGregor, Hamilton, Canada; T. Z. Cason, Jacksonville; Francis M. Massie, Lexington, Ky.; K. K. Sherwood, Seattle.  
Proctology—Martin S. Kleckner, Allentown, Pa.; Louis A. Buie, Rochester.  
Anesthesia—C. N. Carraway, Birmingham.  
Surgery—Herbert Acuff, Knoxville; Russell B. Bailey, Wheeling, W. Va.; Randolph L. Clark, Jackson, Miss.; George Curtis, Columbus, O.; T. C. Davison, Atlanta; Michael de Bakey, New Orleans; James W. Gibbon, Charlotte; Stuart W. Harrington, Rochester; Frank S. Johns, Richmond; J. B. Lukins, Louisville; J. M. Mason, Birmingham; Roy D. McClure, Detroit; George Pack, New York City; Edwin G. Ramsdell, New York City; J. D. Rivers, New Orleans; R. L. Sanders, Memphis.  
Genito-Urinary Surgery—Edgar G. Ballenger, Atlanta; Robert Herbst, Chicago; Nelse F. Ockerblad, Kansas City; Lawrence P. Thackston, Orangeburg; Roy B. Henline, New York City.  
Orthopedic Surgery—Austin T. Moore, Columbia; Leslie V. Rush, Meridian.  
Pediatric Surgery—Stanley J. Seegar, Milwaukee.  
Neurosurgery—Cobb Pilcher, Nashville; Exum Walker, Atlanta.

The completed program will be mailed out between the fifteenth of February and the first of March. Make plans to attend. For information, write Dr. B. T. Beasley, Secretary-Treasurer, 701 Hurt Building, Atlanta, Georgia.

## REGION II, AMERICAN ACADEMY OF PEDIATRICS

The annual meeting of Region II of the American Academy of Pediatrics will be held at the Edgewater Gulf Hotel, at Edgewater Park, Mississippi, on Friday and Saturday, March 15 and 16, 1940.

Edgewater Park is located between Biloxi and Gulfport, in the very center of what has been properly spoken of as the Riviera of America. It is on the main line of the Louisville and Nashville Railroad and on the famous Old Spanish Trail (U. S. Route 90), which connects Florida with California. Edgewater Park is a semi-tropical, winter pleasure community overlooking the Gulf of Mexico, with more than 300 acres of its own premises devoted to outdoor recreation.

An extraordinarily interesting program has been prepared for the scientific session and in addition to clinical papers, a wide variety of roundtable and panel discussions have been planned. Opportunity will likewise be afforded for a delightful recreation on the Gulf Coast during its most attractive season.

In spite of the high quality of service for which the Edgewater Gulf Hotel is famed, the following moderate rates have been quoted for this meeting: \$6.50 and \$7.00 single, \$6.00 and 6.50 each person in double rooms, daily, American plan.

Region II of the Academy of Pediatrics comprises the southern states from Virginia to Texas and a cordial invitation is extended to any physician to attend this meeting.

It is suggested that reservations be made immediately by writing directly to the hotel.

## COUNCILORS' REPORTS

### SECOND DISTRICT—

B. A. WILKINSON, M. D. *Tallahassee*  
Calhoun, Franklin, Gadsden, Gulf, Jackson, Jefferson, Leon, Liberty, Wakulla.

The Franklin-Gulf County Medical Society has become incorporated. A committee has been appointed by Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society to arrange for the incorporation of that society. Dr. Joyner of Jackson County states that he was to bring the matter before his society at their January meeting and I have not heard the wishes of that society with regard to incorporation.

The Jackson County Medical Society is willing to assume supervision in medical questions in Calhoun County until such time as it may be able to organize a society in Calhoun County.

### FOURTH DISTRICT—

JAMES L. STRANGE, M. D. *McIntosh*  
Alachua, Marion, Levy, Citrus, Sumter, Hernando, Pasco, Gilchrist, Bradford, Union.

As councilor for the Fourth District I am glad to report the existence of a great deal of enthusiasm among the members of the medical profession with respect to the steps that are now being made toward a more solid organization of medicine. A definite spirit of cooperation and interest are quite evident and it seems from the efforts that are being put forth and the changes brought about that every one will soon realize the effectiveness of these endeavors.

All the county societies in my district, save one which is too small, have been incorporated for some time. Levy, Bradford, Gilchrist and Union counties, which have never been organized, will now receive official recognition in organized medicine as they have been taken over in a supervisory manner by Marion and Alachua County Societies.

Two societies in the Fourth District have voted to accept the program of the Farm Security Administration, the details of which are to be worked out by committees. I feel sure that the other society in this district will do likewise when more information is received about the project and a list of clients are available.

Read before the Pre-Convention meeting, Jacksonville, January 21, 1940.



My local medical society, Marion, unanimously agreed to an increase in state dues and I feel very certain that the other societies in my district will also agree when they are more thoroughly informed of the necessity of this increase.

I am, no doubt, safe in stating that the members of the profession in the Fourth District are always ready and willing to cooperate in any reasonable manner with any act or idea that pertains to a better organization of medicine.

#### SIXTH DISTRICT—

GEORGE M. GREEN, M. D. . . . . *Daytona Beach*  
Volusia, Flagler, Putnam.

During the past year in the Sixth District of the State Medical Association there have been several activities, namely, the Florida Medical Association meeting in Daytona Beach in May, the Northeast District meeting in Palatka in September, and the Florida East Coast Association meeting in Ponte Vedra in November. These meetings have been reported in detail in the Journal and need only to be mentioned here. All were well attended and successful from every standpoint.

During the past year, I feel that the societies in the district have been more closely affiliated and are on a better cooperative basis than they have ever been. This not only applies to the local district, but to all the other districts whose meetings I have attended. Each request for cooperation that I have made to the societies has fully been carried out and reported accordingly.

It has been the endeavor of the council to incorporate all of the societies and I wish to report that this had already been done in Putnam County, and at the present time Volusia County has voted its approval and incorporation proceedings are being taken care of by an attorney.

At each of the societies it has been brought up and asked to increase our dues to the necessary amount to help take care of our depleted emergency fund. This met with whole-hearted cooperation on the part of all the individuals in both Putnam and Volusia counties.

Also, I have tried to stress to the societies, the importance of care in the selection of delegates to the State Meeting in Tampa, so that their delegates will not just be there merely as representatives in name only, but that an endeavor should be made to see that someone interested in the society and fully informed on Medical Association affairs be elected to this very important position. I have also endeavored to bring the doctors who live in counties not affiliated with any society and with too small a membership to form their own, into membership in some adjacent county. I wish to report there is one doctor in Flagler County who has been accepted and invited into the Volusia County Medical Society.

Let me now congratulate Dr. Herman Watson on his many accomplishments during the past year and to thank him for all he has done to aid us in this district, feeling fully that by his efforts he has shown that no better man could have filled his very important job, Chairman of the Council.

I also wish to thank the members of this district for the cooperation that I have received during the past year.

#### SEVENTH DISTRICT—

W. C. McCONNELL, M. D. . . . . *St. Petersburg*  
Hillsborough, Pinellas, Manatee, Sarasota.

My report may be summarized by saying that "all is well along the Tampa Bay District" and that the component societies are well organized and are in harmony in supporting any reasonable legislation by the House of Delegates for the Florida Medical Association.

#### EIGHTH DISTRICT—

HERMAN WATSON, M. D. . . . . *Lakeland*  
Polk, Hardee, DeSoto, Highlands, Charlotte, Lee, Glades, Hendry, Collier.

The societies in this councilor district have probably been more active this year than ever before, especially in the matter of programs. Much emphasis has been put on improvement of scientific programs and the increased interest of members has proved this as valuable to the society.

As a whole, the membership is about the same as during the previous year with the exception of the addition of some new men locating in the district.

As Councilor, I have been in communication with the secretary of each society in the district from time to time and have visited officially all but one of the societies, having an engagement to visit that one in February. I find in these visits that the men expect the councilor to be familiar with and ready to answer any question pertaining to the State Medical Association in regard to the mechanics of the organization as well as the various activities and the financial reports. They are very much interested in knowing how the state association is spending the money collected in annual dues.

All societies have been incorporated or are being incorporated and I believe that the condition of all the societies is a healthy one.

#### TENTH DISTRICT—

ADRIAN M. SAMPLE, M. D. . . . . *Ft. Pierce*  
Indian River, Okeechobee, St. Lucie, Martin.

The Tenth Councilor District comprising St. Lucie-Okeechobee-Indian River and Martin counties made several steps forward during the past year. During the early part of the year the local Medical Society embracing these counties was incorporated as requested by the state association.

Organized medicine in this district very actively cooperated with the state association in helping to pass the Basic Science Law. Largely through the help of local physicians, our representation at Tallahassee voted four to one in favor of the bill.

The local Medical Society and individual members have cooperated 100 per cent with anything the state association felt would help further the purposes of the profession, just recently voting unanimously in favor of an increase in annual dues to supply funds as suggested.

Practically all of the practicing physicians of the four counties are members of the local society which had a 100 per cent paid up membership the past year.

We are looking forward to November, 1940, at which time the South Central District will hold its annual meeting in Ft. Pierce.

#### TWELFTH DISTRICT—

KENNETH PHILLIPS, M. D. . . . . *Miami*  
Dade, Monroe.

Increased interest in the function and welfare of organized medicine has been demonstrated in both these county societies during the past year. There can be little doubt that the function and activity of the district council has aided in this progress. Through its effort in conveying the views of President Robinson and his executive staff to the membership at large, definite action has been taken upon at least three important matters. First, that Monroe County has taken definite steps to incorporate her County Medical Society. They have also become active in their fraternal interest in the State Medical Association and extended an invitation to the district to hold its 1940 meeting in Key West. This has been accepted and the meeting arranged for the weekend of November 2. This will afford an opportunity for splendid entertainment and a good attendance is anticipated. The second and third matters of importance concern the Dade County Society. While probably

disappointing to many, nevertheless a definite expression of opinion has been elicited in regard to the raising of state dues. They voted at their December meeting to oppose an increase in state dues at this time. Information concerning the state identification law as applied to physicians wherever their names appear such as directories, telephone books, etc., has been disseminated.

The Dade County executive committee has been active in the study and discussion of several of the lesser branches of therapeutics in attempting to determine whether they become subject to the provisions of the Basic Science law.

During the past year there has also been considerable discussion terminating in the expression of opinion at the Dade County Medical Society that the state society should look with disfavor upon insurance companies dealing in hospitalization insurance and also instituting clauses in their policies dictating physicians' medical fees.

## MARRIAGES AND DEATHS

### MARRIAGES

Dr. Hillard W. Willis and Miss Josephine Glass, both of Coral Gables, were married December 29, 1939.

\* \* \*

Dr. R. Bradner Mertz and Miss Christine Mills, both of Tampa, were married December 30, 1939.

\* \* \*

Dr. Leland H. Dame and Miss Mary Lee Price, both of West Palm Beach, were married December 18, 1939.

\* \* \*

Dr. H. S. Howell and Miss Rocena Edwards of Lake City were married January 7.

\* \* \*

Dr. Karl Boyles Hanson and Miss Evelyne St. John, both of Jacksonville, were married January 25, 1940.

\* \* \*

### DEATHS

Dr. Frank E. Kauffman of Clearwater, a member of the Pinellas County Medical Society, died January 29, 1940.

## STATE NEWS ITEMS

Dr. I. W. Chandler of Avon Park was recently appointed by Governor Cone as a member of the State Board of Medical Examiners.

\* \* \*

Dr. Clayton E. Royce and Dr. L. Y. Dyrenforth of Jacksonville recently established a downtown office in the St. James Building, where a qualified medical technician will be on duty daily from 9 a. m. to 5 p. m. This office and laboratory will handle blood counts, urinalyses, cerebrospinal fluids, ordinary blood chemistry and other clinical diagnostic work.

Florida doctors who attended the annual meeting of the American Academy of Orthopedic Surgeons in Boston, January 21 to 25, were: Frank L. Fort, Charles B. Mabry and Paul H. Martin of Jacksonville.

## WILLIAM HENRY DODDS

Dr. William H. Dodds, beloved physician and surgeon of St. Cloud for the past twenty years, died at the Orlando Sanitarium on November 26, 1939.

Doctor Dodds was born in Shelbourne, Ontario, Canada, October 31, 1870, a member of a distinguished and prominent pioneer family of Owen Sound, Canada. Coming to the United States at the age of 19, he received all of his medical education in this country, graduating from Bennett Medical College, Chicago, in 1901.

For a number of years following his graduation he practiced in Poy Sippi, Wisconsin, but moved to Daytona Beach, Florida, prior to the World War. During the War he was stationed in Panama City, as Associate Surgeon of the United States Public Health Service.

In 1920 Doctor Dodds was married to Miss Wilhelmina Ruscher of Cincinnati, Ohio, and the same year he began his practice at St. Cloud.

Doctor Dodds was a past Noble Grand of the I.O.O.F. Lodge, a past Master of the St. Cloud Lodge 221, F. & A. M. of St. Cloud, a member of Olivet Commandery, Knights Templar, Orlando; a member of the Orange County Medical Society, the Florida Medical Association, and the American Medical Association. He is survived by his widow and three daughters.

To know Doctor Dodds was to be his friend. Quiet, unassuming and modest, his urge was always to be of service to the people of his community, and the entire community mourns his passing.

FOR SALE OR RENT—Due to the death of Dr. William H. Dodds, his ideal location, office, equipment and practice are for sale or rent. Write Mrs. William H. Dodds, Box 1072, St. Cloud, Fla.



## COMPONENT COUNTY SOCIETIES

### ALACHUA COUNTY MEDICAL SOCIETY

The Alachua County Medical Society held its regular meeting at the Primrose Grill, Gainesville, on January 11, with the president, Dr. E. H. Andrews, in the Chair. The scientific program consisted of a paper by Dr. T. H. Davis on "The Treatment of Gonorrheal Arthritis By Using Neoprontosil Intradermal," which was discussed by Doctors Andrews, Anderson, and Murphree.

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### BROWARD COUNTY MEDICAL SOCIETY

The annual Election of Officers of the Broward County Medical Society was held on the evening of December 29, and resulted as follows: president, L. B. Elliston; vice-president, Robert E. Blount; secretary-treasurer, E. C. Chamberlain; delegates to State Association convention, R. L. Elliston, E. M. Hendricks; and alternate delegate, O. C. Brown.

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### COLUMBIA COUNTY MEDICAL SOCIETY

The Columbia County Medical Society elected its officers for 1940 at a meeting held in the Blanche Hotel, Lake City, on January 5. Elected were: president, Laurie J. Arnold; vice-president, T. H. Bates; secretary-treasurer, Harry S. Howell; delegate to State Association convention, R. B. Harkness; alternate delegate, E. C. Crouch.

\* \* \*

### DADE COUNTY MEDICAL SOCIETY

Due to the proximity of the New Year's holidays to the regular scheduled date of the Dade County Medical Society meeting, the January get-together was postponed to the evening of January 12. The scientific program consisted of the following papers: "The Diagnostic Significance of Abdominal Wall Pain" by Dr. Donald Smith, discussed by Drs. Francis W. Glenn and James K. McShane; and "Congenital Polycystic Kidney" by Dr. Lee Elgin, discussed by Drs. Perry Melvin and Frederick Dieterich.

### DESOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

The DeSoto-Hardee-Highlands County Medical Society held its Election of Officers at the Hotel Simmons, Wauchula, on the evening of January 9. Those elected to serve for the ensuing year were: president, H. E. Boorum, Sebring; vice-president, M. A. Collier, Wauchula; secretary-treasurer, H. V. Weems, Sebring. Drs. H. V. Weems and L. W. Martin of Sebring were selected to represent the Society as delegates at the next annual meeting of the Florida Medical Association.

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### DUVAL COUNTY MEDICAL SOCIETY

Dr. Robert B. McIver was principal speaker at the January meeting of the Duval County Medical Society which was held in the Library of the State Board of Health Building, Jacksonville at 8:15 p. m., January 2. His paper on "Plastic Surgery of the Renal Pelvis" was illustrated by lantern slides and colored motion pictures.

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### FRANKLIN-GULF COUNTY MEDICAL SOCIETY

The annual Election of Officers was held by the Franklin-Gulf County Medical Society on December 21. On this occasion the society was guest of Dr. A. E. Conter of Apalachicola, and the members turned out 100 per cent strong. Elected were: Thomas Meriwether of Wewahitchka, president; L. H. Bartee of Port St. Joe, vice-president; J. R. Norton, Port St. Joe, secretary-treasurer; and Thomas Meriwether, delegate. It was decided to hold the January meeting at Port St. Joe.

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### JACKSON COUNTY MEDICAL SOCIETY

Dr. W. R. Wandeck of Marianna was elected president of the Jackson County Medical Society at a meeting held in Marianna in January. Other officers named were: J. B. Dowling, Alliance, vice-president; R. N. Joyner, Marianna, secretary-treasurer; and C. D. Whitaker, Marianna, delegate to the State Association convention.

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON  
COUNTY MEDICAL SOCIETY

The quarterly meeting of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society was held at the Florida State Hospital on the afternoon of January 18, with nearly 100 physicians in attendance. The following program was presented:

"Our State Medical Association," Leigh F. Robinson, Ft. Lauderdale; president of Florida Medical Association.

"Cooperation in the Interest of Florida," A. B. McCreary, Jacksonville, State Health officer.

"Surgical Treatment of Epilepsy," J. G. Lysterly, Jacksonville.

"Surgical Treatment of Hydronephrosis" (illustrated with lantern slides and colored motion pictures), Robert B. McIver, Jacksonville.

"Report of Spontaneous Hemorrhage from the Ovary and a Partial Review of the Literature," J. S. Turberville, Century.

At the banquet which was held at the hospital that evening, Dr. C. H. Ryals of Grand Ridge, heralded as "the second Will Rogers," was special guest.

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## MONROE COUNTY MEDICAL SOCIETY

The Monroe County Medical Society has become the third society to report 100 per cent of dues for 1940. Serving as officers for this year are: Harry C. Galey, president; Paul D. Holloway, vice-president; and William R. Warren, secretary-treasurer.

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## ORANGE COUNTY MEDICAL SOCIETY

The Orange County Medical Society held its annual banquet at 8 o'clock on the evening of January 16. Officers of this society are: Frank D. Gray, president, Orlando; Thos. E. McBride, vice-president, Apopka; secretary, Fred Mathers, Orlando; and treasurer, H. C. Ingram, Orlando.

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## PALM BEACH COUNTY MEDICAL SOCIETY

The Palm Beach County Medical Society met for a dinner session at the George Washington Hotel on the evening of January 22. The scientific program consisted of a paper by Dr. Thomas E. Daly on "Pathology, Symptomatology, Diagnosis and Electrocar-

diography of Coronary Heart Disease," which was illustrated by lantern slides.

Officers of this society for the current year are: James H. Pittman, president; W. O. Arnold, vice-president; C. J. Derrick, secretary; and Frederick K. Herpel, treasurer.

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PASCO-HERNANDO-CITRUS COUNTY MEDICAL  
SOCIETY

Dr. Edwin H. Brown entertained the Pasco-Hernando-Citrus County Medical Society at the Edwinola Hotel, Dade City, January 11. A chicken dinner was enjoyed, followed by a meeting in the hotel.

Minutes of the last meeting were read and adopted.

Dr. Edwin H. Brown presented a very interesting paper on "History of Physical Findings and General Report on 333 Appendicitis Cases."

Dr. G. R. Creekmore invited the society to hold its next meeting with him at Brooksville, February 8, 1940.

Those present were: Drs. E. H. Brown, J. T. Bradshaw, G. R. Creekmore, S. C. Harvard, W. W. Jones, and W. H. Walters.

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## PINELLAS COUNTY MEDICAL SOCIETY

The growth of the Pinellas County Medical Society has been rapid. It has become the fourth society in size in the State Association and has this year climbed over the hundred mark, with a membership of 104.

At the meeting of this society held at the Shrine Club on January 5, the members of the local bar association were guests. The principal speaker was Major Frank I. Hanscom, member of the New York State Board of Parole, who presented an interesting discussion on "Parole in Relation to Crime."

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## POLK COUNTY MEDICAL SOCIETY

Lake Wales doctors were hosts to the members of the Polk County Medical Society on January 17. Some 65 Polk County doctors and 25 visiting doctors from other parts of the state were in attendance.

During the afternoon the members and auxiliary of this society were guests of the staff of the Lakes Wales Hospital where they made a tour of inspection. Members of the auxiliary enjoyed a dinner at the Walesbilt Hotel.

The principal speakers of the evening were



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Dr. W. C. Davison, dean of the medical school at Duke University, and Dr. Louis M. Orr of Orlando.

\* \* \*

#### SARASOTA COUNTY MEDICAL SOCIETY

Dr. Millard B. White was elected president of the Sarasota County Medical Society at a joint meeting of the Sarasota and Manatee County Medical Societies held at the Waffle Shop in the Whitfield Estates on December 19. Other officers are: Arthur L. Matthews, vice-president; Stanley T. Martin, secretary-treasurer. Dr. Millard B. White was selected to represent the society as delegate at the next convention of the State Association, with Dr. W. H. Hoskins as alternate.

Dr. W. H. Hoskins of Venice presented a paper on "Arthritis: Classification, Treatment, and Preventive Measures."

### ADVERTISERS' NOTES

#### PROGRESS IN TREATMENT OF PNEUMONIA

In summarizing the great advances that have been made in the development of sulfonamide derivatives for the treatment of bacterial infections, Lord (*New England J. Med.*, **221**: 570, 1939) points out that reduction in the fatality rate of pneumonia from 25 per cent to 7 per cent has been brought about in a large group of adults treated with sulfapyridine. The combined use of sulfapyridine and antiserum will doubtless prove more effective than either alone.

It is desirable to begin treatment with sulfapyridine as soon as the diagnosis is established. If no sputum is available, examination may be made of material taken on a pharyngeal or laryngeal swab, and blood cultures should routinely be made at suitable intervals. In view of the possibility of toxic reactions, blood examinations should include hemoglobin, red-cell, and white-cell determinations and differential counts.

In treating a case with sulfapyridine, it is helpful to make daily determinations of the level of sulfapyridine in the blood. From 3 to 6 mg. per cent of the free drug is ordinarily sufficient for the desired chemotherapeutic effect. Upon the request of physicians Eli Lilly and Company will supply a pamphlet which includes an outline of this method, as well as full details of the treatment.

#### THE PSYCHOLOGICAL ASPECTS OF COD LIVER OIL ADMINISTRATION

Some authorities recommend that cod liver oil be given in the morning and at bedtime when the stomach is empty, while others prefer to give it after meals in order not to retard gastric secretion. If the mother will place the very young baby on her lap and hold the child's mouth open by gently pressing the cheeks together between her thumb and fingers while she administers the oil, all of it will be taken. The infant soon becomes accustomed to taking the oil without having its mouth held open. It is most important that the mother administer the oil in a matter-of-fact manner, without apology or expression of sympathy.

If given cold, cod liver oil has little taste, for the cold tends to paralyze momentarily the gustatory nerves. As any "taste" is largely a metallic one from the silver or silverplated spoon (particularly if the plating is worn), a glass spoon has an advantage.

On account of its higher potency in Vitamins A and D, Mead's Cod Liver Oil Fortified With Percomorph Liver Oil may be given in one-third the ordinary cod liver oil dosage, and is particularly desirable in cases of fat intolerance.

### ABSTRACT DEPARTMENT

*Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.*

**The Influence of Malarial Infections on the Wassermann and Kahn Reactions, KITCHEN, S. F., Tallahassee; WEBB, E. L., Atlanta, Ga.; and KUPPER, W. H., Miami Beach, J. A. M. A. **112**: 1443-1449 (Apr. 15). 1939.**

There has been for a number of years a controversy as to the effect of malarial infections on the serology of patients, most authorities believing that positive Wassermann or Kahn reactions in malaria were due to syphilis rather than some effect of the malaria on the antigenic factors.

From the work of these authors the controversy seems settled in favor of those who held that the malaria itself could produce positive Wassermann and Kahn reactions. In a series of twenty-five patients, known to be non-syphilitic, naturally induced attacks of malaria were accompanied in every instance by positive Wassermann or Kahn reactions. Seventy-two per cent of the positive reactions were obtained during the third and fourth weeks following inoculation. The infections with plasmodium vivax seemed to produce a greater percentage of positive reactions than did falciparum infections. Also the positive reactions were higher among females than among males, and higher among persons up to the age thirty-five than in persons above that age.

The importance of this study lies in the question as to the reliability of positive serologic reactions in people who live where malaria is endemic. Certainly it is of paramount importance that malaria first be ruled out, for positive serologic reactions during malaria can be found at almost any stage of the disease.





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\*"Treatment of Acute Anterior Urethritis with Silver Picrate," Knight and Shelanski, AMERICAN JOURNAL OF SYPHILIS, GONORRHEA AND VENEREAL DISEASES, Vol. 23, No. 2, pages 201-206, March, 1939.

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## WOMAN'S AUXILIARY

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Mrs. W. W. HARDEN, Southwest "D".....St. Petersburg  
Mrs. FRANK D. GRAY, South Central "E".....Orlando  
Mrs. H. A. LEAVITT, Southeast "F".....Miami

## AUXILIARY ACTIVITIES

The dates for the State Meeting to be held at Tampa will be April 29, 30 and May 1. Mrs. Rollo Packard of Chicago, President of the National Woman's Auxiliary and Mrs. Charles P. Corn of Greenville, South Carolina, President of the Woman's Auxiliary to the Southern Medical Assn., will be guests.

\* \* \*

Mrs. L. C. Ingram, State President and Mrs. J. A. Pines, State Publicity Chairman visited the Jacksonville and Gainesville Auxiliaries, January 11 and 12 and were delightfully entertained at both places.

Both organizations were well represented and their work shows progress along all lines.

Mrs. J. E. Maines, Jr., Gainesville, was appointed Public Relation Chairman, to fill out the unexpired term of office.

\* \* \*

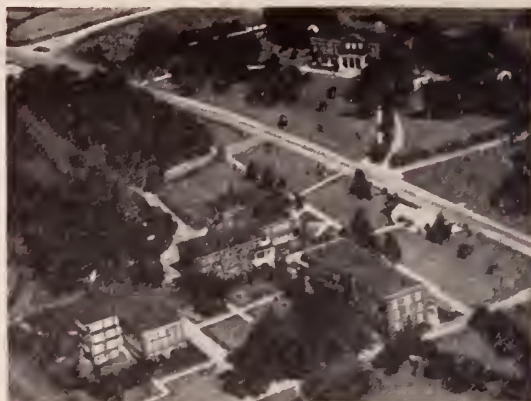
## NOTICE

It is now time for us to pay our State and National dues. They must be in by March 1, 1940. Each organization has the necessary blanks, so forward them to our State Treasurer at your earliest convenience—the sooner the better.

\* \* \*

### BROWARD COUNTY AUXILIARY

The December Auxiliary Meeting was held the afternoon of December 6, 1939 at the home of Mrs. John Allan Johnston. The afternoon was spent in addressing and assem-



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bling the letters containing 5,000 Christmas seals which are sent out each year by the Broward County Tuberculosis and Health Assn. Our organization sponsors the sale of Christmas Seals each year.

Miss Bessie C. Graham, Chairman of the Broward County Tuberculosis and Health Assn., was also present.

The Broward County Medical Auxiliary sponsored a program on Cancer Control at the Ft. Lauderdale Woman's Club on November 14. This program was put on in cooperation with the Women's Field Army.

Interesting posters and graphs were exhibited and explained by the speakers: Mrs. J. Ralston Wells, Daytona Beach, who is State Commander of the Women's Field Army; Dr. Leigh Robinson, President of the Florida Medical Assn.; Dr. R. L. Elliston, President of the Broward County Medical Society; the principal speaker, Mrs. J. W. McMurray, Chairman of the Welfare Department of the Woman's Club, who arranged the program; and Mrs. B. D. Arnold, President Ft. Lauderdale Woman's Club, who presided.

This is one of the programs on Health Education planned by the County Auxiliaries over the state in keeping with the objectives of the Auxiliaries for the year 1940.

\* \* \*

#### ORANGE COUNTY AUXILIARY

While no reports of the Orange County Auxiliary have appeared in the Journal for some time it does not mean the organization has not been functioning. Meetings are held regularly the fourth Tuesday of each month and are well attended.

Reported at a meeting held January 23 at the Angebilt Hotel were three health programs where speakers and films were provided by the Woman's Auxiliary to the Orange County Medical Society. Dr. Gilbert Osincup gave a talk on communicable diseases and their prevention. Dr. Spencer Folsom spoke on diseases of the heart in adults and children, at the Sorosis Club on their Civic Day program.

Dr. L. C. Ingram and Dr. W. P. Rice spoke before our P. T. A. organization and a school group.

The Hygeia Chairman reported forty six-



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**GYNECOLOGY**—Two Weeks' Course April 22, 1940. One Week Personal Course Vaginal Approach to Pelvic Surgery, April 8, 1940.

**OBSTETRICS**—Two Weeks' Course April 8, 1940. Informal Course every week.

**OTOLARYNGOLOGY**—Two Weeks' Course starting April 8, 1940. Informal Course every week.

**OPHTHALMOLOGY**—Two Weeks' Course starting April 22, 1940. Informal Course every week.

**CYSTOSCOPY**—Ten Day Practical Course rotary every two weeks. One Month and Two Weeks' Courses in Urology every two weeks.

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month subscriptions as gifts to all city and county schools, hospitals and libraries.

A generous cash donation to Goodfellows at Christmas time was also noted.

The guest speaker at this meeting was Rosalie Slaughter Morton, physician and author of Winter Park, who gave an intensely interesting talk on the life of the Finns, especially stressing the activities of the women.

\* \* \*

#### PINELLAS COUNTY AUXILIARY

The following is sent in by the Pinellas County Press Chairman dated January 13:

"The Auxiliary to the Pinellas County Medical Society met on Tuesday, January 9, at the Carleve Hotel, for luncheon and a social meeting. There were thirty-two ladies present including nine guests. Following the luncheon, Elmer Ermatinger gave an interesting talk on spring fashions. Mrs. Francis Eaton then gave a splendid book review to the group. She reviewed, "The Hudson," by Carl Carmer.

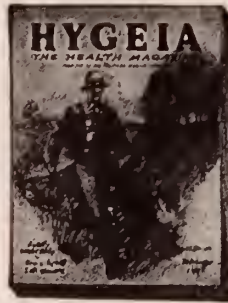
There is to be a meeting of the executive board this coming week to consider the remaining business for the year. The next Auxiliary meeting will be held February 6 at the Virginia Tavern."

### BOOKS RECEIVED

*Acknowledgment of books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review, as expedient.*

TREATMENT IN GENERAL PRACTICE (2 vols.—American Edition). In his Preface to these two volumes, Reginald Fitz outlines the general nature of the texts, as follows: "Recently the British Medical Journal carried out an interesting experiment. A series of articles on treatment was published, each article written by a well-known clinical teacher thoroughly familiar with his subject. Later the various articles were gathered together and published in book form. There were two volumes to the series. The first dealt with treatment of the acute infectious diseases and of cardio-vascular disease; the second with treatment of more chronic conditions such as diseases of the nervous system, diseases of the blood and blood-forming apparatus, rheumatism, diseases of metabolism, and kidney diseases.

"Each article in these two volumes is well written. Dr. Hugh Clegg, who is largely responsible for the general plan of developing these books, kept in mind two guiding principles: to make the series practical above all things, and to convey the teaching in clear-cut shape, even to the point of dogmatism. The various contributors have followed out these principles in an unusually effective manner. They have done their best to describe treatment of various diseases, clearly, simply, dogmatically, and in detail. . . . The two volumes are now published in the United States. They should be of help not only to General Practitioners but also to teachers and medical students." Cloth. Pp. 259 and 436. Price, \$7.50. Boston: Little, Brown & Co., 1939.



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## COMPONENT SOCIETIES BY DISTRICTS — FLORIDA MEDICAL ASSOCIATION

| Districts                                                | COUNTY SOCIETIES                         | PRESIDENT                                                           | SECRETARY                                                          | MEETING DATE                                                           | COUNCILOR<br>and Counties Not Included in First Column | Members |      |
|----------------------------------------------------------|------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|---------|------|
|                                                          |                                          |                                                                     |                                                                    |                                                                        |                                                        | Total   | Paid |
| Northwest District (A)<br>Pensacola<br>Oct. 5, 1940      | Bay                                      | Amsle H. Lisenby, M.D.<br>Panama City                               | William C. Roberts, M.D.<br>Panama City                            |                                                                        | A-1-'40<br>Carol C. Webb, M.D.<br>Pensacola            | 11      |      |
|                                                          | Escambia                                 | Sidney G. Kennedy, M.D.<br>511 American Nat. Bk. Bldg.<br>Pensacola | W. E. Tugwell, M.D.<br>Box 860<br>Pensacola                        | 2nd Tuesday<br>8:00 P. M.                                              |                                                        | 43      |      |
|                                                          | Walton-Okalosa                           | A. G. Williams, M.D.<br>Lakewood                                    | R. B. Spire, M.D.<br>DeFuniak Springs                              | 3rd Thursday<br>8:00 P. M.                                             |                                                        | 6       | 100% |
|                                                          | Washington-Holmes                        | R. H. Segrest, M.D.<br>Bonifay                                      | L. H. Paul, M.D.<br>Bonifay                                        |                                                                        | Santa Rosa                                             | 8       |      |
|                                                          | Franklin-Gulf                            | Thos. Meriwether, M.D.<br>Wewahitchka                               | J. R. Norton, M.D.<br>Port St. Joe                                 | 3rd Thursday                                                           | A-2-'41<br>B. A. Wilkinson, M.D.<br>Tallahassee        | 6       |      |
|                                                          | Jackson                                  | W. R. Wandek, M.D.<br>Marianna                                      | R. N. Joyner, M.D.<br>Marianna                                     | 2nd Tuesday<br>7:30 P. M.                                              |                                                        | 12      | 8    |
|                                                          | Leon-Gadsden-Liberty-Wakulla-Jefferson   | Francis T. Holland, M.D.<br>208 Midyette-Moor Bldg.<br>Tallahassee  | B. A. Wilkinson, M.D.<br>Telephone Bldg.<br>Tallahassee            | Quarterly<br>3:00 P. M.                                                | Calhoun                                                | 39      | 19   |
| North Central District (B)<br>Lake City<br>Oct. 4, 1940  | Columbia                                 | L. J. Arnold, Jr., M.D.<br>Lake City                                | Harry S. Howell, M.D.<br>Blanche Hotel Annex<br>Lake City          | 1st Monday<br>7:30 P. M.                                               | B-3-'41<br>W. S. Nichols, M.D.<br>Lake City            | 21      | 9    |
|                                                          | Madison                                  | E. Long, M.D.<br>Madison                                            | A. F. Harrison, M.D.<br>Madison                                    |                                                                        |                                                        | 3       | 1    |
|                                                          | Taylor                                   | Geo. H. Warren, M.D.<br>Perry                                       | Ralph J. Greene, M.D.<br>Perry                                     | Last Friday<br>8:00 P. M.                                              | Baker-Dixie-Hamilton-Lafayette-Suwannee                | 7       |      |
|                                                          | Alachua                                  | Edwin H. Andrews, M.D.<br>134 N. Pleasant St.<br>Gainesville        | J. Maxey Dell, Jr., M.D.<br>333 W. Main St., S.<br>Gainesville     | 2nd Wednesday<br>7:30 P. M.                                            | B-4-'40<br>James L. Strange, M.D.<br>McIntosh          | 29      |      |
|                                                          | Marion                                   | Henry C. Dozier, M.D.<br>9 No. Magnolia St.<br>Ocala                | R. C. Cumming, M.D.<br>Commercial Bank Bldg.<br>Ocala              | 3rd Thursday<br>12:30 P. M.                                            |                                                        | 3       | 100% |
|                                                          | Pasco-Hernando-Citrus                    | Wm. H. Walters, Jr., M.D.<br>Lacoochee                              | G. R. Creekmore, M.D.<br>Brooksville                               | 2nd Thursday<br>7:00 P. M.                                             |                                                        | 15      | 8    |
|                                                          | Sumter                                   |                                                                     |                                                                    |                                                                        | Bradford-Gilchrist-Levy-Union                          | 2       |      |
| N. E. District (C)<br>Daytona Beach<br>Oct. 3, 1940      | Duval                                    | Chas. B. Mabry, M.D.<br>439 St. James Bldg.<br>Jacksonville         | Lauren M. Sompayrac, M.D.<br>459 St. James Bldg.<br>Jacksonville   | 1st Tuesday<br>8:15 P. M.                                              | C-5-'41<br>R. B. McIver, M.D.<br>Jacksonville          | 177     | 85   |
|                                                          | St. Johns                                | Donald T. Rankin, M.D.<br>East Coast Hospital<br>St. Augustine      | Vernon A. Lockwood, M.D.<br>East Coast Hospital<br>St. Augustine   | 3rd Tuesday<br>8:30 P. M.                                              | Clay-Nassau                                            | 11      |      |
|                                                          | Putnam                                   | G. M. Zeagler, M.D.<br>Glendale Hospital<br>Palatka                 | Bernard E. Kane, M.D.<br>Crescent City                             | 2nd Tuesday in<br>Feb., April, June,<br>Aug., Oct., Dec.<br>7:00 P. M. | C-6-'40<br>George M. Green, M.D.<br>Daytona Beach      | 11      | 5    |
|                                                          | Volusia                                  | L. V. L. Brown, M.D.<br>DeLand                                      | R. L. Miller, M.D.<br>258½ S. Beach St.<br>Daytona Beach           | 2nd Tuesday<br>7:30 P. M.                                              | Flagler                                                | 40      |      |
| Southwest District (D)<br>Dunedin<br>Oct. 31, 1940       | Hillsborough                             | John R. Bolling, M.D.<br>1207 First Nat. Bk. Bldg.<br>Tampa         | James S. Grable, M.D.<br>811 Citizens Bank Bldg.<br>Tampa          | 1st Tuesday<br>8:00 P. M.                                              | D-7-'41<br>W. C. McConnell, M.D.<br>St. Petersburg     | 107     | 43   |
|                                                          | Manatee                                  | M. M. Harrison, M.D.<br>Professional Bldg.<br>Bradenton             | W. E. Wentzel, M.D.<br>Box 245<br>Bradenton                        | 3rd Tuesday<br>7:00 P. M.                                              |                                                        | 14      |      |
|                                                          | Pinellas                                 | John A. Herring, M.D.<br>259 Third St., No.<br>St. Petersburg       | W. C. McConnell, M.D.<br>313 First Federal Bldg.<br>St. Petersburg | 1st and 3rd Fridays<br>6:30 P. M.                                      |                                                        | 104     | 77   |
|                                                          | Sarasota                                 | Millard B. White, M.D.<br>151 S. Pineapple Ave.<br>Sarasota         | Stanley T. Martin, M.D.<br>Sarasota                                | 2nd Tuesday<br>8:30 P. M.                                              |                                                        | 15      | 3    |
|                                                          | DeSoto-Hardee-Highlands-Charlotte-Glades | Hartley E. Boorum, M.D.<br>37-38 S. Ridgewood Drive<br>Sebring      | Howard V. Weems, M.D.<br>22 Oak St.<br>Sebring                     | 2nd Tuesday<br>8:00 P. M.                                              | D-8-'40<br>Herman Watson, M.D.<br>Lakeland             | 20      | 8    |
|                                                          | Lee                                      | A. S. Byle, M.D.<br>311 2nd St.<br>Fort Myers                       | Fred D. Bartleson, M.D.<br>Fort Myers                              | 3rd Friday<br>7:30 P. M.                                               |                                                        | 13      |      |
|                                                          | Polk                                     | Henry Fuller, M.D.<br>Mulberry                                      | Jere W. Annis, M.D.<br>Box 1021<br>Lakeland                        | 2nd Wednesday<br>1:00 P. M.                                            | Collier-Hendry                                         | 62      |      |
| South Central District (E)<br>Ft. Pierce<br>Nov. 1, 1940 | Brevard                                  | I. M. Hay, M.D.<br>Melbourne                                        | I. K. Hicks, M.D.<br>Melbourne                                     | 3rd Tuesday                                                            | E-9-'40<br>W. C. Page, M.D.<br>Cocoa                   | 9       |      |
|                                                          | Lake                                     | W. L. Ashton, M.D.<br>Umatilla                                      | Oliver Emerson, M.D.<br>Tavares                                    | 1st Thursday<br>12:30 P. M.                                            |                                                        | 17      | 8    |
|                                                          | Orange                                   | Frank D. Gray, M.D.<br>19 W. Washington St.<br>Orlando              | Fred Mathers, M.D.<br>Box 53<br>Orlando                            | 3rd Wednesday<br>8:30 P. M.                                            |                                                        | 84      | 43   |
|                                                          | Seminole                                 | Wm. H. Garner, M.D.<br>Sanford                                      | Douglas G. Scott, M.D.<br>212 N. Park Ave.<br>Sanford              | 2nd Monday<br>7:00 P. M.                                               | Osceola                                                | 12      |      |
|                                                          | St. Lucie-Okeechobee-Indian River-Martin | Francis A. Gowdy, M.D.<br>Ft. Pierce                                | Adrian M. Sample, M.D.<br>Ft. Pierce                               | 3rd Thursday<br>8:00 P. M.                                             | E-10-'41<br>A. M. Sample, M.D.<br>Ft. Pierce           | 17      | 10   |
| S. E. District (F)<br>Key West<br>Nov. 2, 1940           | Broward                                  | L. B. Elliston, M.D.<br>814 Sweet Bldg.<br>Ft. Lauderdale           | E. C. Chamberlain, M.D.<br>720 Sweet Bldg.<br>Fort Lauderdale      | 4th Wednesday<br>8:00 P. M.                                            | F-11-'40<br>Lloyd J. Netto, M.D.<br>West Palm Beach    | 36      | 2    |
|                                                          | Palm Beach                               | James H. Pittman, M.D.<br>Box 602<br>W. Palm Beach                  | C. Jennings Derrick, M.D.<br>Box 574<br>W. Palm Beach              | 4th Monday<br>8:00 P. M.                                               |                                                        | 62      |      |
|                                                          | Dade                                     | Joseph S. Stewart, M.D.<br>1105 Huntington Bldg.<br>Miami           | Franz Stewart, M.D.<br>1105 Huntington Bldg.<br>Miami              | 1st Tuesday<br>8:30 P. M.                                              | F-12-'41<br>Kenneth Phillips, M.D.<br>Miami            | 293     |      |
|                                                          | Monroe                                   | Harry C. Galey, M.D.<br>532 Fleming St.<br>Key West                 | W. R. Warren, M.D.<br>511 Eaton St.<br>Key West                    | 1st Sunday<br>9:00 P. M.                                               |                                                        | 5       | 100% |

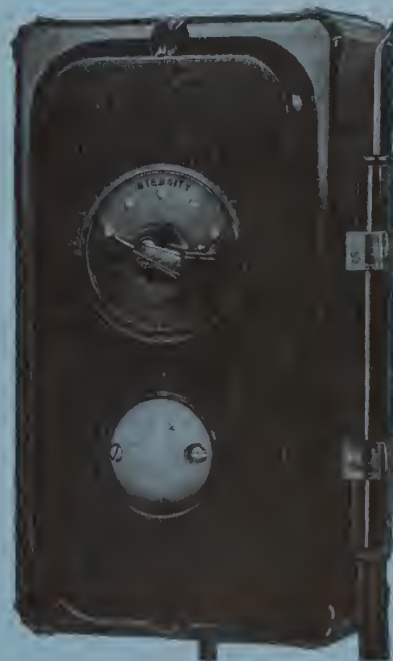


STATE AND SECTIONAL MEETINGS

| SOCIETY                             | PRESIDENT                          | SECRETARY                           | ANNUAL MEETING                   |
|-------------------------------------|------------------------------------|-------------------------------------|----------------------------------|
| Florida Medical Association.....    | Leigh F. Robinson, Ft. Lauderdale  | Shaler Richardson, Jacksonville.... | Tampa, Apr. 29, 30 & May 1, 1940 |
| Florida Medical Districts:          |                                    |                                     |                                  |
| A—Northwest .....                   | B. A. Wilkinson, Tallahassee....   | Stewart Thompson, Jacksonville....  | Pensacola, Oct. 5, 1940          |
| B—North Central .....               | William S. Nichols, Lake City....  | " " "                               | Lake City, Oct. 4, 1940          |
| C—Northeast .....                   | Robt. B. McIver, Jacksonville....  | " " "                               | Daytona Beach, Oct. 3, 1940      |
| D—Southwest .....                   | W. C. McConnell, St. Petersburg..  | " " "                               | Dunedin, Oct. 31, 1940           |
| E—South Central .....               | A. M. Sample, Ft. Pierce.....      | " " "                               | Ft. Pierce, Nov. 1, 1940         |
| F—Southeast .....                   | Kenneth Phillips, Miami.....       | " " "                               | Key West, Nov. 2, 1940           |
| Alabama Medical Association.....    | M. S. Davie, Dothan.....           | D. L. Cannon, Montgomery.....       | Birmingham, April 16-18, 1940    |
| Georgia, Medical Assn. of.....      | W. H. Myers, Savannah.....         | E. D. Shanks, Atlanta.....          | Savannah, April 23-26, 1940      |
| Florida—                            |                                    |                                     |                                  |
| State Dental Association.....       | E. B. Penn, Miami.....             | E. C. Lunsford, Miami.....          | St. Petersburg, Nov., 1940       |
| Soc. of Derm. and Syph.....         | Alan Brown, Jacksonville.....      | Lauren M. Sompayrac, Jacksonville.. | Tampa, 1940                      |
| East Coast Medical Association..... | I. M. Hay, Melbourne.....          | J. S. Stewart, Miami.....           | Miami, 1940                      |
| State Hospital Association.....     | J. H. Therrell, Chattahoochee....  | Mr. Fred M. Walker, Jacksonville..  | Mississippi, March, 1940         |
| Assn. of Industrial Surgeons.....   | Harrison A. Walker, Miami Beach    | A. M. Bidwell, Tampa.....           | Tampa, Apr. 29, 1940             |
| Internists' Society.....            | Norval M. Marr, St. Petersburg..   | Kenneth Phillips, Miami.....        | Tampa, Apr. 29, 1940             |
| Medical Postgraduate Course.....    | Turner Z. Cason, Jacksonville....  | Chairman                            | Jacksonville, 1940               |
| Soc. of Ophthal. & Otol.....        | S. B. Forbes, Tampa.....           | Temporary Chairman.....             | Tampa, Apr. 29, 1940             |
| State Nurses Association.....       | Mrs. M. Stetson, St. Petersburg    | Mrs. Phyllis Leonard, St. Augustine |                                  |
| Pediatric Society .....             | Warren W. Quillian, Coral Gables   | G. N. Leonard, Miami Beach.....     | Tampa, 1940                      |
| Pharmaceutical Association .....    | Mr. S. F. Harris, Jacksonville.... | Mr. A. W. Morrison, Miami.....      | Tampa, May, 1940                 |
| Public Health Association .....     | A. B. McCreary, Jacksonville....   | E. M. L'Engle, Jacksonville.....    | Tampa, Dec., 1940                |
| Radiological Society .....          | H. B. McEuen, Jacksonville.....    | J. N. Moore, Ocala.....             | Tampa, Apr. 29, 1940             |
| Railway Surgeons' Association.....  | H. D. Clark, Ft. Pierce.....       | W. C. Page, Cocoa.....              | Tampa, Apr. 28, 1940             |
| Tuberculosis & Health Assn.....     | Mr. G. E. Therry, W. Palm Beach..  | Mrs. May Pynchon, Jacksonville....  | Spring, 1940                     |
| Chattahoochee Valley Med. Assn..... | M. Y. Dabney, Birmingham.....      | Frank K. Boland, Atlanta.....       | Albany, Ga., July 9-11, 1940     |
| Gulf Coast Clinical Society.....    | J. H. Dodson, Mobile.....          | C. C. Rouse, Mobile.....            |                                  |
| Southeastern Derm. Assn.....        | Jack Jones, Atlanta.....           | Howard Hailey, Atlanta.....         | Atlanta, Ga., Sept. 1, 1940      |
| Southeastern Surgical Congress..... | R. L. Sanders, Memphis.....        | B. T. Beasley, Atlanta.....         | Birmingham, Mar. 11-13, 1940     |
| Southern Medical Association.....   | Arthur T. McCormack, Louisville    | Mr. C. P. Lorz, Birmingham.....     | Louisville, Ky., Nov., 1940      |
| Swansee River Medical Society.....  | T. H. Bates, Lake City.....        | H. S. Howell, Lake City.....        |                                  |

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No. 9

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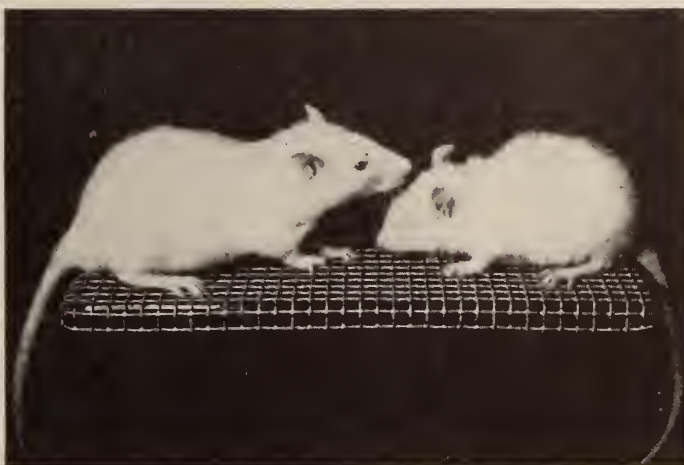


# STUDIES IN THE AVITAMINOSES

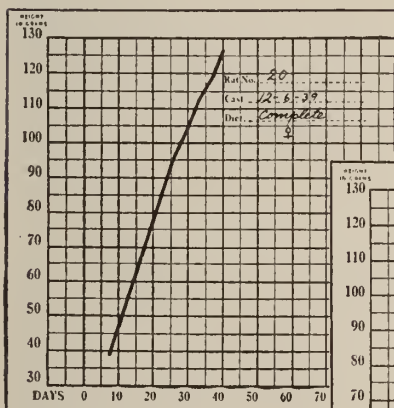


This page is the third of a series on vitamin deficiencies presented by the research division of The Upjohn Company because of the profession's widespread interest in the subject. A full color, two-page insert on the same subject appears in the March 9 issue of The Journal of the American Medical Association.

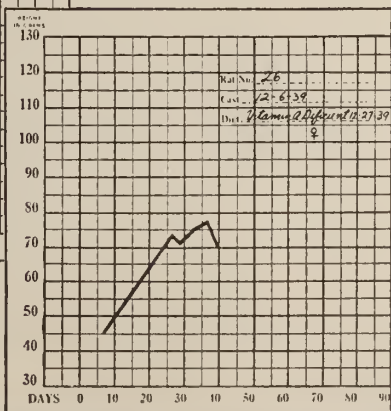
**I**NHIBITION of growth in the rat produced by restriction of vitamin A in the diet. The animals, litter mates, were 21 days old at the start of the experiment which was continued for 33 days. The animal at right received a diet containing all nutritive substances except vitamin A; the animal at left, an adequate diet. Note the xerophthalmia in vitamin A deprived rat.



## Retardation of Growth Due to Vitamin A Deficiency



The upper graph records the growth of a rat on a complete diet. The lower graph records the growth of a litter mate on a vitamin A deficient diet; it depicts almost immediate retardation and cessation of growth.



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*Laryngoscope, Feb. 1935,  
Vol. XLV, No. 2, 149-154*

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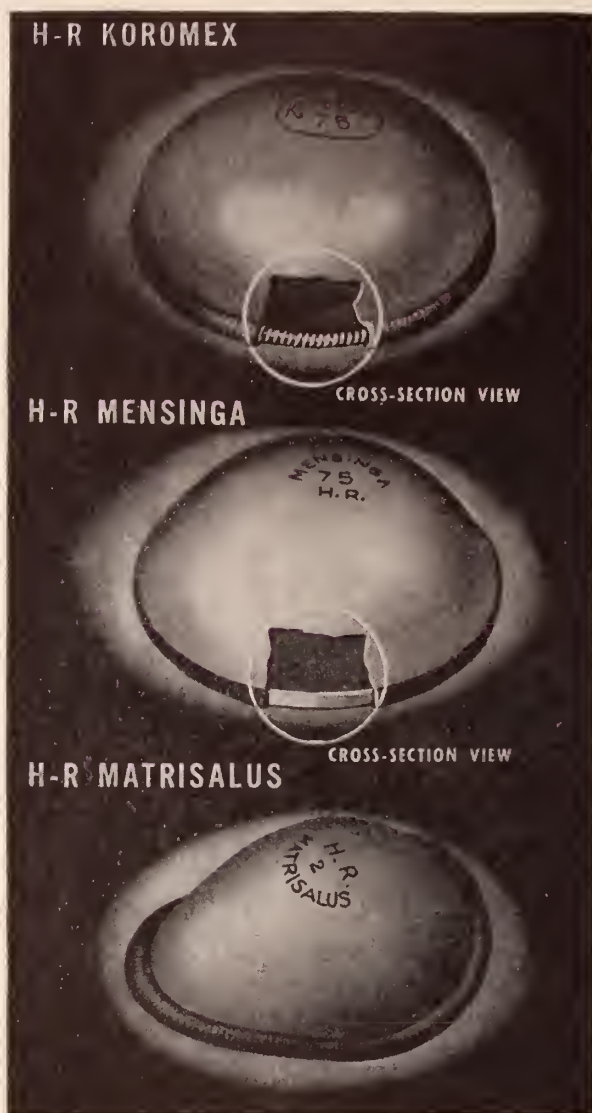
that such control is very helpful in the management of these patients.

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## MYELOGENOUS LEUKEMIA

WILLIAM G. DOERN, M. D.

Daytona Beach

Myelogenous leukemia is a progressing, fatal disease characterized by uncontrolled cell growth involving certain hematopoietic tissues of the body of man and also of lower animals and some fowls.

A review of medical literature indicates a rather wide variation in the observations and the conclusions of our leading researchers as to the cause and the nature of myelogenous leukemia. The uncertainty resulting from these varied and unsupported conclusions is further reflected in the failure of treatment of this disease. Statistics show that, until very recently, the best treatment known did not materially lengthen the life-span of leukemic patients after the onset of the disease from what it was one hundred years ago, nor had any treatment offered more than temporary or symptomatic relief.

I will refer to the writings of some of our good authorities on this subject. Doctor Isaacs of Michigan, who has had a very wide experience in the study of leukemia clinically and in the laboratory, pointed out the close relationship of leukemia to cancer and emphasized the following observations:

1. Uncontrolled cell growth with metastasis.
2. Fatal termination with cachexia.
3. Neoplastic type of cell metabolic rate.
4. Maturation of cells under irradiation.
5. Absence of bacterial etiology.
6. Birth of normal children to leukemic mothers.

*(I agree with the first four observations listed, but take exception to observations 5 and 6).*

Piney contends that myelogenous leukemia is neoplastic because he observed medullary and extramedullary foci of immature cells of a single type. Naegeli contends that myelogenous leukemia is not neoplastic and non-bacterial but is due to dysfunction of glands of internal secretion. Bernard produced typical leukemic blood pictures by injecting tar into the blood stream of animals.

Lignac found similar leukemic blood pic-

tures after injection of small amounts of benzene into the blood stream of animals. *(I contend that the chemicals, used in a very unnatural manner to produce leukemia or to produce any type of tumor, must be regarded as contributory factors only and not as specific etiological agents because their presence has not been demonstrated in the leukemias and tumors developing nonexperimentally.)*

Kracke contends the leukemic process is excited by some unknown agent which will not become known until we know the cause of all uncontrolled cell growth. Slye observed that heredity is a factor in causing leukemia. She found that all her mice which developed leukemia were of a certain cancer strain. She further observed that if both parent mice were leukemic, their later offspring developed leukemias in 100 per cent of the animals.

I wish to announce three cardinal observations from my own clinical and animal research studies of myelogenous leukemia:

1. That myelogenous leukemia is neoplastic of the malignant type, characterized by uncontrolled cell growth with immature cell production and immature cell metastasis.
2. That the agent which excites the affected cells to uncontrolled cell production is a specific leukemic micro-organism which I isolated and cultured from the blood of human leukemic patients and with pure cultures of which I have produced typical myelogenous leukemia in more than three hundred animals.
3. That the leukemia micro-organism has a selective affinity for both the male and the female sex cell and may be transmitted to the offspring provided the leukemic infection existed long enough in the parent for the leukemia germ to have implanted itself in the sex cell in its mature or resting stage before conception.

Our concept of myelogenous leukemia becomes clearer if we regard the uncontrolled growth of the hematopoietic cells, the secondary impacted or proliferating immature cells, the increased leukocytes circulating in the blood stream, and the cells collected by the spleen, liver, and other organs and tissues of the body, as constituting one tumor. Because of the nature and position of the cells attacked

a large portion of that tumor may be constantly circulating.

The history of a leukemic patient invariably shows a forerunning infection or a systemic disturbance of bacterial type. Most commonly I have observed a mouth infection about the teeth, the tonsils, or the sinuses, with possible secondary infection of the gallbladder or other areas of the body. Other leukemic patients give a history of boils or other pyogenic infections.

From clinical and experimental observations I have concluded that the specific leukemic infection is fostered and fed by products of forerunning bacterial action, and I made use of that principle in preparing culture media on which were grown the specific leukemia germ from the blood of leukemic patients. Likewise in the treatment of leukemia it is imperative that every focus of infection which can be located be eliminated.

In 1937 I cultured my micro-organism from the blood of patients afflicted with leukemia and demonstrated that germ within the white blood corpuscles of leukemic patients. The leukemia germ is a very small, actively motile micrococcus which may be seen under a magnification of 2,500 diameters on a beam of intense light. The magnification required is two and one-half times that used in general bacteriology. The illumination required is twenty-five times that used in general laboratory work. The illumination I use is a direct beam of light from a four hundred watt bulb passed through a condenser and through a filter which is the complement of the stain used, or is a complement of the index of the leukocytes, when the examination is made directly from the fresh, unstained leukemic blood. With that equipment I found the leukemia micrococcus alive and actively moving within the leukocytes of the blood of patients afflicted with leukemia, and if disintegrated leukocytes were observed, the leukemia micrococcus was seen free in the blood plasma.

#### CULTURES OF LEUKEMIA MICROCOCCUS

The leukemia micrococcus may be grown on artificial culture media from the blood of leukemic patients. I have used plain slightly alkaline bouillon or bouillon-agar to which I have added previously prepared by-products of bacterial decomposition of organic matter. With pure cultures from human leukemic

blood grown on this special culture medium, the first animal inoculations produced well-defined and typical leukemia in thirty-six mice. Myelogenous leukemia may now be induced readily in mice, rats, and rabbits by inoculating with pure cultures of this germ. The same micrococcus was recovered from the blood of leukemic animals and cultured on artificial media outside of the animal. I have met all the requirements of Koch's postulates to show that this very small actively motile micrococcus found in the leukocytes of leukemic patients is the direct and specific etiological factor in leukemia.

#### DIRECTIONS FOR MAKING CULTURE MEDIUM

1. Grind one pound of celery stalks and leaves, one pound of head lettuce, and one pound of fat-free beef. Place in a large flat open pan, cover with 1,000 cc. of chlorine-free unsterile water and allow to decompose for 48 hours at incubator temperature. Add water to maintain fluid at 1,000 cc. if evaporation takes place.
2. At the end of 48 hours boil for 20 minutes and filter through old muslin.
3. To 1,000 cc. of filtrate add dried pepton 10 grams and sodium chloride 5 grams.
4. Add potassium hydrate solution to make slightly alkaline.
5. Sterilize under 20 pounds pressure and filter through old muslin if flakiness appears. (Preferably not through too fine a filter.)
6. Be sure that the finished medium is slightly alkaline. It may be used as a bouillon or, if a solid medium is desired, add 1½ per cent agar.

#### CULTURES

On the above medium cultures of the leukemia germ may be made from a drop of blood of a patient afflicted with myelogenous leukemia during the acute stage of the disease, or during an acute exacerbation of chronic myelogenous leukemia.

The culture of the leukemia germ on the surface of hard medium will appear as a smooth, slightly elevated, moist, glistening, creamy colored growth which has a tendency to wrinkle and turn brownish in color as the growth ages, especially if it dries. If completely dried, the growth contracts into islands or ridges, brownish yellow in color. The germ retains its viability for a long time in the dry state.



The leukemia germ in the blood appears as a very small micrococcus when viewed under 2,500 diameters magnification (a, Fig. 1). When seen in culture, however, or in stained

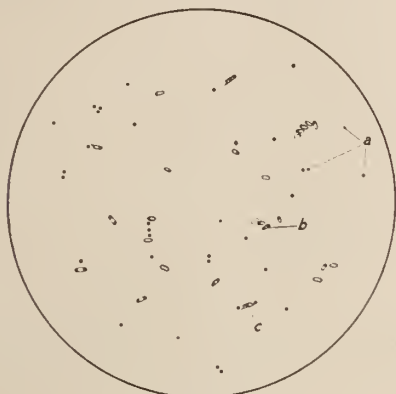


Fig 1

Microscopic View of Cultured Leukemia Micro-organism X 2500

smears made from cultures, the small micrococcus is usually inclosed within a more or less complete capsule, (b and c, Fig. 1).

In bouillon the culture of the leukemia germ slightly clouds the medium with a creamy, slimy growth.

#### MICROSCOPIC STUDY OF LEUKEMIA GERM

The leukemia germ may be observed in fresh, unstained blood of leukemic patients in the acute stage of the disease and also during acute exacerbations. This requires magnification of 2,500 diameters and an intense light beam passed through a color filter which is the complement of the color of the leukocyte and the germ. When present in fresh blood the little micro-organism will be seen as a very small, round, actively motile micro-organism within the leukocyte, or if there are degenerated and disintegrated leukocytes, this micrococcus may be seen moving in the plasma between the blood cells. In fresh live blood the leukemia micrococcus may be distinguished from normal leukocyte granules, which also move with the ameboid mass of the leukocyte, by the more rapid and independent movements.

#### STAINING OF THE LEUKEMIA GERM

The staining fluid must contain a solvent and a penetrant. For staining smears of cultures I used a freshly prepared solution of gentian violet "B" (Merck and Co.) dissolved in equal parts of chloroform and ether.

1. Make smear from the culture and fix in the usual way.
2. Stain for 8 hours in a bath of filtered saturated solution gentian violet "B" in equal parts of chloroform and ether (no alcohol).
3. Wash thoroughly in water to remove free stain.
4. Dehydrate in air. Do not use alcohol to dehydrate because it removes the stain and destains the micrococcus.
5. Mount with xylol balsam.
6. Examine under 2,500 diameters with strong light through a green filter.

#### STAINING THE LEUKEMIA MICROCOCCUS IN BLOOD

The gentian violet stain is not satisfactory for staining the leukemia micrococcus in the leukocyte because the nuclear and granular elements in the leukocyte take the stain equally with the micrococcus, and it may be difficult to distinguish the germ from the cellular elements. For staining the leukemia germ within the leukocyte I used the following technic:

1. Make the usual blood smear and fix on slide.
2. Treat for 3 hours in a  $\frac{1}{2}$  per cent aqueous solution of nitric acid.
3. Wash thoroughly in water to remove all the acid.
4. Dry thoroughly in air. (Do not use alcohol to dehydrate.)
5. Stain for 4 hours in a bath of filtered saturated solution of Bismark brown dissolved in water.
6. Wash thoroughly in water.
7. Dry well in air.
8. Clear in xylol for 15 minutes.
9. Mount in xylol Canada-balsam using 00 cover glass.

With this staining technic the leukocytes will stain light brown. The leukemia micrococcus described will be seen distinctly with a deeper brown stain within the leukocyte or free in the field with or near disintegrated leukocytes.

The discovery of the true nature of leukemia will, no doubt, point the way to a more efficient treatment than has been available in the past.

Any skilled technician can duplicate my work on myelogenous leukemia and verify my findings within four months by following the

instructions given in this paper from culture of the germ from blood of human leukemic through induced animal leukemia to cultures again from the leukemic animal's blood. Successful animal inoculations have been made by intravenous and by subcutaneous injections with suspensions of the cultured germ. The animals used in the order of preference were white rabbit, white rat, and white mouse. I will furnish material and assistance on request from any laboratory technician interested in duplicating this work.

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## PEDIATRICS FIFTY YEARS AGO AND TODAY

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A dozen books like Victor Heiser's *An American Doctor's Odyssey*, were of sufficient historical inspiration last summer for me to send to the American Medical Association library for many reprints on the history of pediatrics, and to desire to trace pediatrics under Holt and Hotch, as it was taught in "the gay nineties" at Harvard, through the evolution of civilization to the remarkable advances of today when Science is ever challenging Nature. The Miami City Hospital librarian handed me a homeopathic treatise on *Diseases of Children* published in 1854 by Alphonse Teste of Paris. Quoting from the translator, Emma Coté, in her preface:

It has ever been one of the most flagrant reproaches of the Allopathic system that its violent and repulsive remedies should be so barbarously inapposite to the peculiar sensibilities of childhood. Drugs, so revolting in smell, taste and quantity, and so inevitably productive of derangement and prostration, in the strongest of constitutions, as to severely test the resolution even of adults, have to be forced by manual cruelty, upon the convulsive repugnance of helpless infants, with the certainty of introducing new distresses purely medicinal.

Under Scarlatina she translates:

Homeopathy would proceed with a mathematical precision, if the correlation of the remedy and of the symptoms was as definite and clear in all diseases as it is in simple scarlatina. Belladonna is literally the specific in all its periods, and is a certain preventive against the scarlatinous infection, as is aconite in measles.

Such faith in drug therapy as compared to the beginning of drug nihilism in my medical

school days! Then the fine points of differential diagnosis with the five senses were stressed. A diagnosis of diabetes, pernicious anemia and, to a less degree, cancer and tuberculosis, was a death-warrant. There were no x-rays; fractures were detected under ether by palpation. Hospital laboratory work meant urinalysis, Widal, malaria, blood (no Wassermann) and a few bacteriological examinations. Pathological sections were done in the nineties.

Drug skepticism increased, so that in January, 1898, our family physician, Dr. Othello Bourland, Jr., a scholarly gentleman of the "old school," sent me a reprint, *Therapeutics Without Drugs*. Quoting from the immortal bard of Avon, "throw physics to the dogs. I'll none of it," Doctor Bourland suggested that "cures might be effected with proper adjuvant therapy that would be incurable with drugs alone." And yet he, too, from long habit, later prescribed adult drugs to my nephew which were all promptly vomited. A change to hydrotherapeutic and dietary treatment cleared up the edema, ascites, coffee-ground vomitus, pallor, and bloody oliguria of an acute hemorrhagic nephritis.

On the old Boston Floating Hospital it was our custom in 1899 and 1900 to give routinely ten doses of 1/10 grain calomel to nearly all infants following this with "a good dose of castor oil," needed or not.

A starvation diet of barley or albumin water, flies, lack of milk inspections, bad housing, lues, ignorance of foreign and domestic-born mothers, high fat percentage feeding (3 to 6 per cent), few articles in lay journals, formulae too weak in calories, lack of segregation of babies and children, and food fads—all these produced on our boat a wealth of autopsy material from which Doctors Flexner and Shiga could study the bacteriology and pathology of dysenteries.

Most of our teachers and visiting staffs had taken postgraduate work in Vienna, Berlin or Paris. They had seen the empirical horse and buggy days succeeded in the eighties by two schools of thought:—one, the school of pathology by Virchow; and the other, the new school of bacteriology as exemplified by Pasteur and his co-workers. Pathologists did not recognize pathogenic bacteria as the cause of infection, and sneered at the presence of

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pneumococci and streptococci in the sputum, and at the Klebs-Loeffler bacillus as the cause of diphtheria. My teachers had witnessed an epoch-making series of discoveries which laid the foundation of modern bacteriology. How much this meant to the children of future generations!

#### DIPHTHERIA

Take, for example, diphtheria. Here is Jurine's description of "Croup" in 1850. The word "diphtheria" was unknown; so were bacteria.

The dyspnoea is fearful, the respiration is stertorous, and the suffocation, with all its fearful agony of anxiety and suffering, threatens every moment the life of the child. He, in vain, throws his head backwards, in order to lengthen the trachea, and thus to open a larger passage for the air; his neck swells, his pulse is feeble and intermitting, his eyes sunken and his body covered with a cold perspiration. He suddenly assumes a sitting posture; his face, purple and swollen, expresses extreme anxiety; the eyeballs, rolling to the right and left, are sometimes turned upward in convulsions. Lastly the respirations become slower; the little patient exhausts all his strength in making a few feeble inspirations; the extremities become cold and purple, the pulse smaller and asphyxia impends. Death is like strangulation. The brain shows traces of cerebral congestion and of acute hydrocephalus.

This dreadful disease (said Hering, in 1854) may in the majority of cases be easily and promptly cured by homeopathic remedies. We hardly lose a fifth of the number of those who die under the old treatment. Begin with hepar sulphur, from the first to the third trituration, follow with aconite, 3rd, then hepar and spongia tosta, then samb. nig., hyosc., and cina; sometimes, also, nux vom., veratrum alba, chincona and drosera. When the attacks of suffocation come on, I prescribe tartar emetic, in large doses, then spongia; an arm bath of very warm water; then acon., then spongia, hepar sulphur, then arsenic, bellad., carb. veget, aconit., etc.; in despair a few leeches to the trachea.

"I ask his pardon; but this treatment is miserable," comments Teste, "and I shall give my treatment; very simple, very sure." Then follows his long list of drugs, too.

The Allopathic or old school, in contrast, treated my little sister, in 1894 for "membranous croup" with bichloride of mercury, with or without iron, in 1/30 grain doses up to 1/10 grain at frequent intervals; also croup Kettle, epecae, and squills.

When I entered the Harvard Medical School in 1896, L. Emmett Holt taught us to treat diphtheria with antitoxin alone (plus stimulants). Children under 2 years of age were given 1,500 to 2,000 units for an initial dose in all severe cases. If seen late, even 3,000 units were considered necessary; in mild cases 1,000 units sufficed. A severe case of laryngeal diphtheria required 1,000 units, repeated in 12 hours; in milder cases 600 units

were given. In 1903 at the South Department of the Boston City Hospital, as resident, I gave as high as 100,000 units in extreme septic and laryngeal cases. Since then the pendulum has again swung backward. At present, 10,000 units in membranous croup are given early, intravenously, or 15,000 intramuscularly, repeated in 24 hours to prevent need of intubation or tracheotomy.

What a contrast is today with its mass immunizations of babies and children at the monthly checkup and at school and health clinics; whooping cough immunizations given in the doctor's office when the children are from 5 to 7 months of age, diphtheria at 9 months and Schick tests at 12 to 15 months. If the tests are positive, the alum toxoid, and later, the Schick tests are repeated.

The sharp decline in diphtheria morbidity has increased the danger that sporadic cases will go unrecognized during the earlier stages. With the Brahdys Rapid Culture Tubes containing heated serum-dipped swabs, a culture may be identified in 4 hours. The physician's vest pocket may serve as incubator; the swab contains the culture medium. After 4 hours, the swabs are firmly rolled on slides; the smears are obtained and examined. There is little danger of contaminating germs.

#### SCARLET FEVER

The intensive study of scarlet fever in 1890 by Moser and Escherich, showed streptococci ever present in cultures. Marmorek's antistreptococcus serum was a failure. Mallory took up the study in our Boston City Hospital scarlet fever wards in 1903. In the late spring and during the summer we had no deaths as long as all the ward windows were up and the children got out of doors in tents or on platforms in the sun every day. (This was similar to our results at Miami where the constant sun exposure greatly modifies the streptococcus infections so that our scarlet fever cases are few and mild). But after the Boston schools had opened, the severity increased. On October 3 three patients came in and were dead in 48 hours. Doctor Mallory thought he demonstrated some daisy-like forms in skin sections as did Councilman in cases of smallpox a few years earlier. Mallory thought, too, that he might be demonstrating a protozoon as the cause of scarlet fever, and that the streptococci

were secondary and caused the many complications.

George and Gladys Dick then made an intensive study; their new book<sup>1</sup> on *Scarlet Fever* is just off the press. In diagnosis they stress the history, physical signs, the leukocytosis with eosinophilia, the hemolytic streptococci in blood agar-plate cultures of the nose and throat, the Blanching test which consists of 1 cc. of scarlet fever antitoxin being injected intradermally. It is read 18-24 hours later and is the reliable skin test for susceptibility to scarlet fever, known as the Dick Test. Dick advises giving 6,000 units of scarlet fever antitoxin even in mild cases, because of later possible complications. In more toxic cases Dick advises two to five doses injected into the front of the thigh (quadriceps extensor muscle). Given early and in adequate doses, antitoxin and sulfanilamide give brilliant results. We do not immunize contacts against scarlet fever with the toxoid in Miami, because of the scarcity and mildness of the cases. The reaction may be as severe as the disease. By giving the antitoxin early the results are good. Very few exposed children contracted it this winter and the 13 cases were scattered. The Dick organism is the likely specific factor causing scarlet fever out of many varieties of *Streptococcus haemolyticus*. The Dochez strain as well as strain No. 2 is usually found.

#### WHOOPING COUGH

Dr. L. W. Sauer, in an article on "Whooping Cough" published in the *Journal of the American Medical Association*, January 28, 1938, concludes:

Whooping cough is caused by *Haemophilus pertussis* (coccobacillus of Bordet and Gengou); a filtrable virus plays no role.

*Bacillus parapertussis* (Eldering and Kendrick) causes a pertussis-like cough.

The newly recommended concentration of authorized *H. pertussis* vaccine (1 cc. = 20,000 million organisms) requires a smaller volume of vaccine for active immunization.

Since the benefit of passive immunization is temporary, children so injected should also be given the three customary injections of authorized vaccine for prolonged protection.

It is not yet known whether the frequently observed positive cutaneous test (after the disease, and after active immunization) is an allergic phenomenon or actual proof of immunity.

The present strongest laboratory evidence of vaccine-conferred immunity is a four-plus complement fixation test.

Passive immunity, according to various investigators, occurs when intimately exposed infants are promptly injected with convalescent or hyperimmune serum before the paroxysmal stage.

The treatment of whooping cough with which I have had most satisfactory results is as follows:

1. Fresh air, out of doors, preferably on the beach (salt air is beneficial).

2. Small amounts of food often (about five meals a day) preferably after a coughing paroxysm, even if vomited. (Milk, thick cereals, etc.)

3. A tight abdominal binder, if vomiting; but none on chest.

4. Alternate two rooms for sleeping, and keep away from other cases, to reduce the number of germs.

5. Much rest in bed, if patient is weak from loss of sleep. In this way loss of weight is prevented.

6. A daily movement is necessary, using mineral oil, milk of magnesia, aromatic cascara, enema, or suppository if needed.

7. Inhalations of steam at nap-time and at bed-time, of a teaspoon of compound tincture of benzoin to each pint of steaming hot water, for at least thirty minutes.

8. Applications every other day to chest and back of ultra violet rays to point of slight reddening of the skin.

9. Pertussis antigen every other day (for cure and contacts) 1½ to 2 cc. subcutaneously; three to five doses will reduce complications, paroxysms, and duration, if given early.

10. But, best of all, are the three double preventive shots (Sauer technic) given four months or more before exposure, as drugs are usually unreliable.

#### DISEASES OF THE URINARY SYSTEM

The surgery of the urinary system of the child, exclusive of circumcisions, may be said to fall into five groups:—

1. The infectious—tuberculosis or pyogenic.

2. The calculus deposits, so often a sequel to infections.

3. Tumor formations, affecting kidney—embryonic type.

4. The congenital malformations of bladder and urethra.

5. The neuromuscular errors which are generally evidenced as a disturbance of the act of micturition.

Mandelic acid therapy marks a notable advance in urinary antiseptics, and is successful



in three out of four cases where there is adequate cooperation, dosage, acidification, renal function, period of treatment, freedom from residual urine and from unusual virulence of the invading organism.

#### PNEUMONIAS

In the recent literature are many excellent articles on pneumonias of childhood (broncho and lobar) stressing diagnosis, prognosis and treatment. In sputum typing, other organisms than the usual pneumococcus are found. Friedlander bacilli are found now in adults. Nemir's fine article dealing with the serum treatment of pneumonia in childhood stresses early typing, and the giving of appropriate serum. Rapid improvement usually occurs. No specific serum is available for bronchopneumonia. However, many patients with lobar pneumonia make a spontaneous recovery without serum.

Treatment of pneumonia consists of physical and mental rest, fluids, carbohydrates. Sufficient fluid ingested is judged by the color of the urine. Hydrotherapy, sedatives, stimulants, enemata, oxygen, blood transfusions, and proper treatment for tympanites are at times indicated.

Encouraging reports come in on the new sulfanilamide derivative, sulfapyridine. Moderate cyanosis may show, but decapsulation ensues with consequent loss of type specificity of the organism. Graham<sup>2</sup> reports a mortality with sulfapyridine of 6 per cent as compared with 23 per cent in the control-series. Administered orally, the adult dose was 2 Gm. followed every 4 hours with 1 Gm. until 25 Gm. had been given. As much as 12 Gm. was given in the first 24 hours. Since the drug is still in the experimental stage, the clinical data are insufficient to warrant the general use of the drug, but careful treatment trials have been made in pneumococcic, severe straphylococcic and Friedlander's bacillary infections. It is not evident that sulfapyridine is as effective as, or superior to, sulfanilamide in the treatment of hemolytic, streptococcic, meningococcic, gonococcic or Welch bacillary infections. The drug is slowly absorbed, and slowly excreted. The toxic manifestations are as severe and as frequent as with sulfanilamide. Rational schemes of treatment with sulfapyridine have not as yet been presented. The results with children are the

same as with adults. The drug should be used under controlled investigation. The tablet may be pulverized and suspended in milk or fruit juices, and given before or after meals, or in frequent, smaller doses.

The drug should be administered early, in a relatively large amount, within the shortest possible period to produce an adequate concentration in the blood and body fluids and a satisfactory dose must be maintained.

A combination of specific serum therapy and sulfapyridine results in a higher percentage of recoveries than either alone, and it is recommended that the two therapies be used together if pneumococcus bacteremia is known to be present; if treatment is begun after the third day of illness; or if there is involvement of two or more lobes.

If the type of pneumococcus cannot be determined, or if the specific serum is not available, Dagenan (sulfapyridine) with supportive measures, are indicated. Merck and Cincinnati observers each report 100 cases treated with 4 deaths in one series.

Besides the striking results in pneumonia with the new English derivative, successful application with sulfanilamide in undulant fever, gonorrheal infections in girls, gonorrheal ophthalmia, ophthalmia neonatorum, and nine other diseases, has recently been reported.<sup>3,4</sup>

#### PROGRESS ALONG OTHER LINES

Infant feeding has been reduced to a simple, economic, sterile, constant, safe basis. Evaporated milk, plain and acidified, is justly in great favor today. Protein milk is of value for prematures and "difficult feeders" where there is a tendency to diarrheas. The acidified evaporated cow's or goat's milk has given me best results in allergic, eczematous infants.

Great progress has been made: in the deficiency diseases (avitaminoses) like beri-beri, rickets, and scurvy; also in lumbar, ventricular, and cistern punctures; in vaccines, convalescent sera, and measles' placental extract (immune globulin); in the prevention of infant blindness by the Cr  d   prophylaxis of ophthalmia neonatorum; by the Mantoux, Von Pirquet, and patch tuberculin tests, the patch test being reliable and practical as routine examination in cases of malnutrition; also by the Schick, Dick and Schultz-Charlton

tests. The Calmette vaccine to prevent tuberculosis in infants has been a failure.

One of the greatest aids to the pediatrician was presented by Roentgen in 1895. The x-ray is valuable in rickets, bone syphilis, scurvy, lead-poisoning, bone diseases and fractures, intracranial and pulmonary lesions. But do not delay for an x-ray study in acute appendicitis in a child, when the clinical and blood pictures make the diagnosis obvious.

We are indebted to Banting for his contribution of insulin in infantile, juvenile and adult diabetes. Endocrine therapy in children is limited, but definite advances are fast being made, according to Dr. Isaac Abt in his excellent chapter in the recent *1938 Year Book of Pediatrics*. Doctor Abt sums up such vital and complex subjects as the relation of vitamins to hormones, the connection between the endocrine glands, heredity, the nervous system, environment, and nutrition and metabolism generally. In pediatric endocrinology Doctor Abt selects recent reports on 14 conditions, including juvenile adiposity, diabetes, (free diet, authoritative pronouncements on protamine insulins in children), cryptorchidism, cretinism, etc. Just off the press is Sevringhaus' *Endocrine Therapy in General Practice*. The book is brief and practical enough to assist the physician in every day practice. However, even this new book will soon be out of date, such is the rapid progress being made in the hormones. Anesthetics, too, have made great strides in pediatrics. Transfusions are of value in infancy regardless of age; prematures, hemophiliacs, cases of streptococcus with threat of hemolysis, in leukemias, constitutional inferiority, hemorrhages, sepsis, et al. Advances have been made in allergy, and allergic conditions, e.g., asthma, eczema, protein sensitization, and serum sickness. Food and hay fever tests are of value. The practical wiping out of gastroenteritis by the efficiency of our health departments in securing clean milk in our large cities, is one of the greatest victories of all.

Good prescription writing, cod liver oil and vitamin D certified pasteurized milk, are still in order. The convulsions of tetany are rare today; forty years ago we had "fire service" for them on the old Boston Floating Hospital, so common they were. At that time we gave a milk diet the first year—no solids for

13 months. Now cereals, cooked vegetables, fruit juices, liver, eggs, soups, purées, cod liver oil, bread, rusk, zwieback, potatoes, stewed fruits, and bananas are given to the baby who has a well regulated diet in the first year. Acidifying the milk lessens the tax on the hydrochloric acid of the stomach, an advantage over alkaline lime-water or soda-bicarbonate.

To be avoided are too frequent feedings for the normal baby. Four-hour schedules are the best for mother and infant, except in case of a weak or premature baby. Avoid the multitudinous drugs in the treatment of whooping cough; the detoxified antigen produces little or no local reaction and no sensitization, since human blood, as in the Sauer vaccine, is used in its preparation.

In infantile paralysis, convalescent serum has not proved satisfactory. Vaccines containing active virus, devitalized by sodium ricinoleate or formaldehyde, promise better results.

Finally, we see coming true the prophesy of the real father of pediatrics in America, Doctor L. Emmett Holt, who in his 1923 presidential address to the American Pediatric Society, visualized for the future the development of three distinct types of pediatricists: first, the research man, who is likely to be a full time head of a department in a university medical school; second, the man who applies the best science to the treatment of sick children in the home and in the hospital and dispensary; third, the public health pediatricist, who will organize and direct this special department in a state or city or county health board.

From such organization, efficiency, and research as these three branches of pediatrics represent there can be no doubt that the children of the future will be better equipped to face the struggle of life, because there will be fewer diseases, yet better therapeutics with which to combat them. Pediatrics will be 75 per cent preventive in its scope, including feeding of infants, general hygiene, public education, child psychology and preventive inoculations.

Some years ago the British historian, James Addington Symonds turned prophet and poet and wrote:



These things shall be, a loftier race  
Than e're the world has known, shall rise,  
With flame of freedom in their souls,  
And light of knowledge in their eyes.

In summing up the experience of the past, one finds that then, as now, the greatest morbidity and mortality occurred among the poor and ignorant from infections and malnutrition. The greatest achievements have been made in combating these evils.

The greatest fault of our predecessors probably lay in their too great faith in drugs and bleeding. They can hardly be blamed for their ignorance of physiology, and lest the modern attitude toward their heroic treatments become hypercritical, it is well to remember that some of the serum and intravenous therapy used today may seem equally uncouth to our descendants 100 years from now. One should never cease to admire and to emulate their courage, their patience, and their optimism in the face of ghastly odds. Taking them all in all, they probably exhibited about the same proportion of skill and stupidity, of judgment and error, of poise and of instability as we see today.

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#### DISCUSSION

*Dr. D. D. Martin, Tampa:*

Doctor McKibben has, with great finesse, presented a most interesting and instructive paper on a subject that is of vital interest to many of us. Pediatrics, as a specialty, has progressed much in the past fifty years. The progress of this branch of medicine has not been entirely a bed of roses.

There are many volunteer organizations along with county, city, state and federal health departments that are very actively engaged in the practice of pediatrics. In spite of this, the lone scientific workers in the field of preventive pediatrics, have given us some brilliant and life-saving discoveries.

Doctor McKibben has vividly presented to us the great changes that have been made in the diagnosis and treatment of children's diseases and yet, I believe the next generation will see even more startling discoveries.

Medicine marches on—ever ready and with the will to conquer the seemingly impossible barriers that are always presenting themselves for solution.

Those of us who are engaged in the practice of pediatrics have always to remember that we are general practitioners, limiting our field to the care of infants and children, and we must be ever mindful of the many problems of children and their diseases and continue to be stimulated by a keener sense of duty and responsibility.

#### FRACTURES OF THE PELVIS

##### REPORT OF SEVEN CASES AND THEIR TREATMENT

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Century

Since the motor vehicle has become the popular method of transportation, this type of injury is more frequent. The type of crushing injury which causes it is a common occurrence in automobile, truck and bus accidents. Men who are doing industrial surgery see them quite often also.

#### ANATOMICAL CONSIDERATIONS

The pelvis is a strong bony cage which supports the spine and transmits the weight of the body to both lower limbs. It also affords protection to all pelvic organs, and to muscle and tendon attachments which move the lower limbs. It is made up of two innominate bones each of which is made up of the ilium, ischium, and pubis, and is united in front by the symphysis, and posteriorly by the sacrum which joins the innominate bones at the sacro-iliac joint.

The cavity is divided into a false and true pelvis by a plane drawn through the sacral promontory posteriorly, and the superior portion of the pubis anteriorly. The false pelvis

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is bounded laterally by the wings of the ilia, posteriorly by the lumbar spine, and anteriorly by the abdominal wall. The true pelvis is bounded by all of the bones of the pelvis. At the point of division of the two, there is a prominent ridge, termed the brim of the pelvis.

The innominate bone is made up of 3 separate bones, which fuse early in life. The ilium forms the superior and posterior portion, the pubis the anterior portion, and the ischium the inferior portion. All these unite at the acetabulum. The ilium is composed of a body and wings. The body unites at the acetabulum with the pubis in front, and with the ischium below to make up this joint. Behind, it forms the greater sciatic notch. The pubic bone consists of a body and two rami. The bodies unite in front to form the symphysis. The superior rami unite with the ilium to make up the acetabulum, and the inferior rami unite with the rami of the ischium. The ischium is composed of a body which goes into the formation of the acetabulum, a tuberosity which is used to support the weight of the body while sitting, and a ramus which unites with the inferior rami of the pubis. The latter bounds the obturator foramen. The sacrum is a large, triangular bone which is made up of five fused segments or vertebrae. It unites with the innominate bones and makes up the posterior wall of the pelvis. This is perforated by four pairs of foramina which allow passage for the branches of the anterior sacral nerves. This articulates above with lumbar vertebra, and below with the coccyx (which is made up of five rudimentary vertebrae). The symphysis pubis is a rudimentary joint, and is bound together with dense fibrous ligaments. The sacro-iliac joint is a true one, but the short ligaments which hold it do not allow for much motion.

The pelvis is so constructed that arches are formed which support the body weight, and resist shocks and blows from all sides. It is composed of two main arches; the sacrum is the keystone of both. The femoro-sacral arch extends from the acetabula upward through the thick portion of the ilium to the sacrum, and supports the body weight in the erect position. The ischio-sacral arch extends upward from the ischial tuberosity through the body of the ischium and ilium to the sacrum, and supports the weight while sitting. There

are two tie arches which prevent spreading. The horizontal rami and body of the pubis support the femoro-sacral arch, and the united rami of the ischium and pubis support the ischio-sacral arch. When subjected to a severe strain, the tie arches are usually broken before the main arches are affected. Therefore, most pelvic fractures occur anteriorly, or in the tie arches. If the main arches are broken, usually the tie arches are also broken.

#### EXAMINATION OF THE PELVIS

In most cases the patient is on his back, and may be in profound shock. It is unwise, therefore, to move him until the extent of injury or need of an operation is determined. If there is abdominal pain, the abdomen should be examined for rigidity and dullness in the flanks, and a white blood cell count should be made. The urinary tract should be examined, which will be taken up later. The pelvis should then be palpated gently for deformities and swellings. By gentle compression over the trochanters, pubis and sacrum, the integrity of the ring can be ascertained. The x-ray should be used to make a final diagnosis.

Fractures of the pelvis are not rare. Noland and Conwell report 185 over a period of 12 years. Many cases are never diagnosed, since they are in conjunction with fatal injuries.

Most fractures are caused by severe, crushing blows or direct trauma. If the force comes from the anteroposterior direction, one or both rami are broken, and the posterior ring also if the blow is hard enough. In blows from the lateral direction, the same type tends to occur. Also, falls on the feet may cause the same type.

The classification of pelvic fractures according to Key and Conwell is as follows:

- I. Fracture of individual bones without a break in the continuity of pelvic ring.
  1. Fractures of wing of ilium.
  2. Fractures of single ramus of pubis or ischium.
  3. Fractures of the anterior superior spine of ilium.
  4. Fractures of the ischial tuberosity.
  5. Fractures of the sacrum.
  6. Fracture or dislocation of the coccyx.
- II. Single breaks in pelvic ring.
  1. Fracture through both rami.
  2. Separation at or fracture near symphysis.
  3. Separation at or fracture near sacro-iliac joint.
- III. Double break in pelvic ring.
  1. Double vertical fracture of Malgaigne.
  2. Severe multiple fractures of pelvis.
- IV. Fractures of acetabulum.

This classification includes almost every type of fracture but, according to Conwell,



about 65 per cent show multiple lesions of bone.

Every severe injury in the region of the pelvis should be checked by x-ray. This part of the body is well covered by soft parts, and accurate diagnosis by manual manipulation is impossible. Complications usually cause most of the deaths within the first twenty-four hours, and the pelvic fracture is associated only with the complication. The mortality rate is about 16 per cent (Noland and Conwell). The most frequent complication is rupture of the bladder or urethra. (From 35 per cent to 50 per cent of the fractures have this complication). This should be ruled out by the patient voiding clear urine or by catheterization. There are many other complications, but they are rare. In rupture of bladder, the laceration is usually extraperitoneal, and in the anterior wall near the urethra. This type is associated with fractured rami of pubis, or separation of symphysis. The urethra may be torn, punctured, or completely sectioned, and this occurs usually in the membranous portion. When the bladder is torn and ruptures into the peritoneal cavity, the urine quickly escapes into the cavity. The bladder collapses with a rate proportional to the size of the rent. In extraperitoneal laceration, the urine may travel upward between the transversalis fascia, and downward around the neck of the bladder and prevesical space. In rupture of the posterior urethra, the urine may pass up or down, as in the extraperitoneal rupture of the bladder. In rupture of the urethra in front, the urine infiltrates or extravasates in all directions, even into the penis and scrotum, or labia.

The diagnosis of bladder injury is not difficult. There is pain and heaviness in the lower abdomen, with a desire to void, without results. If the bladder is torn into the peritoneal cavity, there are the usual signs of peritoneal irritation, with nausea, rigidity, vomiting and shock. There are also signs of visceral injury and kidney injury; sometimes large hematomata occur retroperitoneally.

Swelling and tenderness in the suprapubic region occur in extraperitoneal tear. The abdominal symptoms are absent or minute. When blood trickles from the urethra, it is pathognomonic of urethral injury. The distended bladder can be felt above the symphysis. To complete the diagnosis, the patient

should be allowed to void if possible and, if unable, a soft rubber catheter should be used with strict asepsis. If the patient can void, and passes bloody urine, there is a kidney injury; but if urine is clear, there is usually no injury. If the catheter passes into the bladder and only a few drops of blood pass, the tear is into the abdominal cavity; but if urine which is colored with blood passes, the injury is extraperitoneal. If the catheter be passed into the bladder, and on withdrawal shows blood stains on its sides, there is usually rupture of the urethra.

A series of seven cases follows which we have treated, and which show most of the complications except intraperitoneal laceration of the bladder:

#### CASE I. FRACTURE OF CLASS IV

*History:* The patient, a white male, aged 52, came into the hospital following an automobile accident in which he was thrown against the dash board with his knees striking first. He was complaining of marked pain in the left hip region. There was quite a bit of shortening of the left leg, and the hip was somewhat fixed. X-ray examination revealed the head of the femur driven through the floor of the acetabulum. No other fracture noted.

*Treatment:* Under ether anesthesia the femur was pulled out of the acetabulum. Adhesive traction was used with about 25 pounds to start with. This was gradually reduced. The reason for traction was to try to prevent ankylosis. This patient left the hospital about 6 weeks later, against our advice. We saw the patient a few months later, and he had a good anatomical and functional result.

#### CASE II. FRACTURE OF CLASS III, TYPE 2, WITH INJURY TO URETHRA AND URINARY BLOCK

*History:* The patient, a white male, aged 24, came into the hospital 24 hours after having been hit by a locomotive at a grade crossing. He stated that his hips and crossbones had been hurt, and since the accident, he had been unable to void. An attempt to catheterize him was made by the first doctor who saw him. Nothing was gotten but blood, and only a small amount of this.

*Physical Examination:* This was essentially negative other than minor abrasions on the left side of body, with the exception of the pelvic findings. The pelvis was tender on compression from side to side, and antero-posteriorly. The bladder was greatly distended, and fundus was up to umbilicus. X-ray pictures were then made.

*X-ray Findings:* There was a separation of epiphysis of left pubic bone at symphysis, and separation of about 1/3 inch. There was a suggestion of fracture of ischium right and left, but no separation was found. Stereo plates showed fractures of both pubic rami at the angle and junction with ischium. The superior pubic ramus on the right was broken at the superior symphysis angle, and was separated from its fellow of the other side. The ramus had some of the epiphysis of the other side attached to it. There was very little deformity.

*Conclusions:* Multiple fractures of pelvis in pubic region.

*Treatment:* A suprapubic cystotomy was done, and the bladder drained through the abdominal wound and the urethra. The patient was placed on a flat frame which was suspended by inner tubes over a bed. This frame

had canvas stretched tightly over it, and a round, padded hole in its middle for bed pan use; this was covered by a laced flap while not in use.

*Progress of Case:* The patient pulled the catheter out of urethra three days following operation. It was not replaced at the time. Twenty-three days following operation, he developed an abscess in the ischio-rectal region. This was opened, and a few days later mercuriochrome was injected into the abscess cavity; it did not show in the bladder. The abscess cleared up, and fifty-six days following the first operation, a repair of the urethra was done.

*Operation:* A No. 20 sound was passed into the internal meatus, and a No. 24 grooved sound was passed up the urethra, but was unable to enter. A curved incision from one ischial tuberosity to the other was made, and the membranous and prostatic urethra were exposed by blunt dissection. The scar tissue was incised, and a No. 22 soft rubber catheter was passed up the urethra into the bladder while supporting the prostatic portion with two guy sutures. The membranous end and prostatic end were sutured over the catheter. The catheter tip was anchored in the bladder with No. 8 sewing thread looped over a piece of rubber tubing on the outside of the cystotomy opening.

The catheter was changed on the eleventh day following operation. The patient had a little leakage of urine through the perineal wound, but this soon closed. He made an uneventful recovery, and left the hospital ninety-three days after admission. He has been sounded several times since with a No. 26 sound which passes readily. His functional results were good. X-ray showed more separation of symphysis than at the beginning.

#### CASE III. FRACTURE OF CLASS III, TYPE 2

*History:* The patient, a white female, aged 20, came into the hospital giving a history of an automobile accident two hours previously. She complained of her right hip hurting, and the left side of her face. She was thrown out of the car through the door.

*Examination:* This was essentially negative except for pelvic findings. No bladder or urethral injuries were found. The left leg was 1 inch shorter than the right. The left greater trochanter was rather prominent and pushed forward.

*X-ray Examination:* A flat plate showed the rami of the pubic arch on the right to be fractured, and also the ischial ramus in its middle 1/3. The lateral fragment of the pubic ramus was displaced forward, and overlapped 1/2 to 3/4 of an inch. The lateral fragment of the ischial ramus was displaced backward, and overlapped about 1/3 to 1/2 of an inch.

*Treatment:* The patient was put in a canvas cradle which was suspended by inner tubes. This arrangement was similar to the case just described, except that lateral adhesive traction was used on the right leg. The patient remained in the hospital under this treatment for sixty days, and was allowed to go home to stay in bed for thirty more days. She had good functional results, but had a slight limp on the right side which cleared up in about fifteen months. She has had one baby through this pelvis since then, and is now about term with another. She had no trouble with the first baby.

#### CASE IV. FRACTURE OF CLASS III, TYPE 2

This is the case of a white male, aged 22.

*History:* The top of a falling tree lodged in another, and the butt swung around and hit him on the hip. This gave him considerable pain. He was unable to void following this. He was exposed to the elements the greater part of the day, and being unable to get home, he lay down on the wet ground for five or six hours.

*Examination and Findings:* The patient was in considerable shock on admission. He was catheterized, and a large amount of bloody urine was obtained. He complained of considerable pain on manipulating the pelvis.

*X-ray Findings:* The flat plate showed a fracture of the superior and inferior rami of the pubis on the right

side, with separation and downward displacement of the symphysis.

*Treatment:* The patient was placed in a swinging cradle, and a catheter placed in the bladder, getting a large quantity of bloody urine. The catheter was fastened in, and coupled to a bottle. This man developed pneumonia on the fifth day, and died on the fourteenth day. There was no definite treatment as we had to keep the patient turned in the cradle and propped up somewhat.

#### CASE V. FRACTURE OF CLASS III, TYPE 2

*History:* The patient, a white male, aged 32, came into the hospital after having been run over by a fertilizer truck thirty hours previously. Since then he had had extreme pain and soreness in the left side of pelvis, and inability to void. He was catheterized, and a trickle of blood was obtained but no urine.

*Examination:* There was crepitation on the left side of the pelvis. No other positive findings were noted.

*X-ray Findings:* The left ischial and pubic rami were fractured, and the entire ilium was twisted forward. The obturator foramen was distorted, since the rami were fractured at this point. The fragments were widely separated.

*Treatment:* A suprapubic cystotomy was done. A No. 26 sound was passed into urethra, and with index finger guided through the internal meatus into the bladder. A catheter was threaded over the beak of the sound, and pulled out of the urethra. The suprapubic opening was closed around a de Pezzer catheter. The patient was put up in a sling which was swung from a fracture frame, and adhesive traction applied to the left leg. The catheter was removed from the urethra on the twelfth day, and the patient sounded with a No. 20 sound. In passing the sound, it was felt to lunge over a piece of free bone. The patient had a stormy time, but made a good recovery. He left the hospital in sixty days to stay in bed at home another thirty days. He had been sounded at regular intervals until two years ago, and he now comes at infrequent intervals. He has to lie on his left side and pull his left leg up to urinate. He has been advised to have the piece of bone that causes the obstruction removed, but he has not consented as yet.

#### CASE VI. FRACTURE OF CLASS III, TYPE 2

A colored female, aged 18, came into the hospital complaining of having been thrown from a truck about two hours previously. She seemed to be in a state of considerable shock on admission, and her abdomen was extremely rigid. She complained that the right leg, back and right hip hurt her severely.

*Examination:* This was essentially negative, except for rigidity of the lower segment of the abdomen, and tenderness on compression of the pelvis.

*X-ray:* There was a fracture of the pubic and ischial rami on the right, with overlapping of the fragments. The pubic fragments overlapped the ischial. There was separation of the sacro-iliac joint on that side. The ramus of pubis and ischium was fractured on the left side, but in good position. The symphysis was separated and overlapped 1/4 to 1/2 an inch, the left side being superior.

*Treatment:* The patient was put up in a hammock with traction on the right leg. She stayed in the hospital for seventy-five days, and was discharged in good condition. I understand she has had a baby through the pelvis since then.

#### CASE VII. FRACTURE OF CLASS III, TYPE 2

The patient, a white male, aged 29, came into the hospital giving a history of being pinned under an overturned truck. This produced severe pain in the pelvis. He had been unable to void since then. A catheter was passed, but only blood was obtained. The slightest manipulation of the chest produced severe pain.

*Examination:* This was essentially negative, except



for moderate shock, and coarse mucous rales all over the chest. The full bladder could be felt almost up to the umbilicus, but a catheter could not be passed.

*X-ray:* There was a separation of the symphysis, and an over-riding of the fragments. The upper fragment was at least 1/4 inch above the level of the lower fragment, the right over-riding the left. There was some separation of the sacro-iliac joint of the left side, and an actual fracture of the ilium, the posterior superior spine being detached with some of the contiguous bone.

*Treatment:* A suprapubic cystotomy was done, and one-half gallon of urine was evacuated. A No. 26 sound was passed into the external urethral meatus and, with the index finger of the right hand in the internal meatus, the sound was guided into the bladder. The urethral rupture was about 1/2 inch from the internal meatus. A catheter was threaded over the beak of the sound and pulled out. The catheter was then anchored in the bladder with No. 8 sewing thread looped to a piece of rubber tubing on the outside. The bladder was closed around a de Pezzer catheter; the wound was closed in the usual manner. He was then put on the cradle device with traction on his left leg, and some lateral traction on his left thigh. An x-ray picture on the twelfth day following operation showed the pelvis in good position. He developed a perineal abscess which ruptured on the twenty-fifth day. The catheter was removed on the twenty-fifth day following the rupture. He was dilated with a No. 20 sound at regular intervals. He remained in the hospital for about eighty-seven days, and was discharged in good condition. He comes back regularly for sounding, and is now doing hard labor.

## THE TREATMENT OF MENINGOCOCCIC MENINGITIS

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Meningococcic meningitis was, prior to 1908, of necessity treated solely on the basis of symptomatology, and the treatment consisted for the most part in restraint, sedation, warm soaks, and other means of controlling pain, delirium, and convulsions. In some cases lumbar puncture with drainage was used either occasionally or routinely, usually as a means of the relief of symptoms arising from an increase in the intracranial pressure. Blackfan,<sup>1</sup> in his review of the subject of meningococcic meningitis in 1922 quotes Olitsky's claim of reducing the mortality in a series of cases in China by means of drainage via lumbar puncture. He showed a mortality of 84.6 per cent in 106 cases in which lumbar puncture was not used, and a mortality of 54 per cent in 306 cases in which drainage was carried out. The mortality for most of the series of cases reported during this period ran close to 90 per cent, though a mortality rate as low as 42 per cent was reported.

In 1908 Flexner,<sup>2</sup> Jochmann<sup>3</sup> and others produced a specific anti-meningococcus serum

which reduced the mortality rates to an average of 32 per cent for 4,547 reported cases, the highest rate for cases so treated being 37 per cent and the lowest 16.4 per cent, in comparison to a mortality rate of from 49 per cent to 77 per cent for cases not treated with serum. Since the introduction of serum in the treatment of meningococcic meningitis there has been a tendency for the medical profession to sit back and accept as a fact the idea that with the use of serum the mortality rate for meningococcic meningitis is 30 per cent or less, and this attitude has persisted until recently, when, after a check-up in different parts of the country by various men, it was found that the mortality rates ran from around 55 per cent to 90 per cent.

In an attempt to explain and correct this definite rise in the mortality rate it becomes necessary to review the method of attack of the meningococcus. In the first place, Ferry, in 1931, demonstrated the presence of a meningococcal exotoxin and produced a successful antitoxin against it. With the knowledge of the existence of an exotoxin and with our other knowledge of the disease it is possible to set up a logical explanation of the mode of invasion and the symptoms and course of a meningococcic involvement as advanced by Shaw.<sup>4</sup> The meningococcus from its focus at some point in the upper respiratory tract produces its toxin which, unless the subject produces or has an antitoxin already present, causes an injury to the capillaries in this area and this permits of their invasion of the blood stream. From here further growth and exotoxin production brings about the early symptoms, particularly the symptoms seen in the very fulminating cases, consisting in shock and collapse and the presence of numerous petechiae as well as encephalitic symptoms characterized by extreme drowsiness and delirium. In those cases there is frequently no evidence of meningeal irritation. Through further injury to the capillary bed, after they have entered the blood stream, the organisms pass into the meninges and there grow and produce the usual meningeal signs. At this point the signs of toxicity tend to subside and the disease seems to become one due to the bacteria themselves; at least the patient who survives the early stage of toxicity seems later to be affected more by the presence of the bacteria than by the presence of a toxin.

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In checking the method of preparation of the antiserum when it was first produced, it is found that the method used did not attempt to exclude the products of the bacteria from the cultures used so that both an antitoxin and an antibacterial serum was the result. In the refined method developed during the years since the antiserum was first produced, the antitoxin has been eliminated by the use of methods which exclude the exotoxin from the material injected into the animals used.

Following the introduction of an antitoxin, Hoynes<sup>6</sup> in the Cook County Hospital in Chicago, using antitoxin intravenously and using no antibacterial serum and no therapy intrathecally, was able to reduce the mortality at the hospital of from 50 to 90 per cent, to 23 per cent. The use of the antitoxin in other regions also showed reductions in their mortality rates.

In 1937 Schwenker, Gelman, and Long<sup>6</sup> reported a small series of cases in which the sole therapy consisted of the administration of sulfanilamide intrathecally, orally and subcutaneously with a mortality rate of 15 per cent. Since then others have also used sulfanilamide either alone or in conjunction with other forms of therapy and have reported good results.

In reviewing the cases of meningococcic meningitis in the City Hospital of Louisville, Kentucky, we found that over a period of ten years 157 cases had been diagnosed and treated.

The mortality rates for various modes of therapy may be summed up as follows:

|                                                                              | Lived | Died | Mortality % |
|------------------------------------------------------------------------------|-------|------|-------------|
| Treated with antibacterial serum intrathecally . . .                         | 33    | 23   | 41.07       |
| Treated with antibacterial serum intrathecally and antitoxin intravenously . | 48    | 27   | 36          |
| Treated with intravenous antitoxin . . . . .                                 | 6     | 2    | 25          |
| Treated with intravenous antitoxin and sulfanilamide . . . . .               | 14    | 2    | 12.5        |
| Receiving no therapy due to death soon after admittance to the hospital      | 0     | 2    | 100         |

Although the number of cases reported above is too small from which to draw any definite conclusions, these results when considered along with the results reported by

others would lead one to feel very strongly that intravenous antitoxin and sulfanilamide are both very efficacious weapons for the attack on the meningococcus and that the present ideal method of handling cases of meningococcic meningitis is a combination of intravenous antitoxin and sulfanilamide, orally or subcutaneously.

In the administration of antitoxin, relatively large doses are advocated, 25,000 units at each injection for the infant, and as much as 150,000 units at each injection for the adult. The antitoxin should be given slowly, after the sensitivity test is proved negative, by intravenous drip and should be administered with equal parts of 10 per cent glucose.

The sulfanilamide is administered orally, unless the patient is nauseated, in doses on the average of one gram per 20 pounds of body weight per 24 hours with a large amount, two grams per 20 pounds of body weight within 6 hours as an initial broken dose. In case the patient is nauseated and vomiting the drug may be administered subcutaneously, enough of the powder being dissolved in normal saline to make a one per cent solution, 100 cc. per 40 pounds of body weight being administered every 8 to 24 hours. Soda bicarbonate or Hartman's sodium lactate solution may be used to combat the development of an acidosis, and recently methylene blue has been given in conjunction with the drug with the result that cyanosis was prevented along with a great many of the other toxic symptoms of the drug, such as dizziness, nausea, vomiting and dyspnea. It is wise to keep a constant check on the blood of all patients receiving sulfanilamide, and it is suggested that routinely, an initial white blood count, differential, red blood count, and hemoglobin determination be made, and another 24 hours after the drug is started, and a white blood count and red blood count every 48 hours thereafter.

In addition to the fact that the use of a combination of intravenous antitoxin and sulfanilamide apparently offers the greatest chance of recovery from meningococcic meningitis of all the methods at hand at the present time, there is another strong point for its use: that the patient is so much more comfortable and therefore rests so much better than the patient who is treated intraspinally.



This method also permits the treatment of those cases in which the spinal fluid is too purulent to flow through the needle used in making the puncture.

In those cases in which sulfanilamide is not tolerated the antitoxin and antibacterial serum should be given together, and in those cases in which the patient proves too sensitive to be given serum, sulfanilamide alone offers a great deal.

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### ZINC PEROXIDE IN INFECTED WOUNDS

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A surgeon, at some time in his work, may have a complete stymie laid between an infected wound and most orthodox procedures in treatment. It is such a case that drives him into medical libraries in the hope of finding some experience of the other fellow that can be likened to his problem, together with the other fellow's method of treatment. It is with this experience in mind that I wish to review the use of zinc peroxide in a case that resisted every tried procedure in treatment until it promptly succumbed to therapy with this substance.

In 1903 Elias<sup>1</sup> suggested the use of zinc peroxide as an antiseptic, and in 1907 Mayer<sup>2</sup> reported its use in the treatment of some skin lesions. Paucot<sup>3</sup> in 1905 used zinc peroxide in surgical infections at the anal outlet; he was impressed by the increase in the amount of supuration from the wound, soon followed by the appearance of a healthy, bleeding granular surface. Paucot also reported the tendency of zinc peroxide suspension to crust or cake in the wound.

Chaput<sup>4</sup> felt that zinc peroxide approached the ideal antiseptic in that it was not toxic, it did not irritate the wound, and it could be

sterilized without impairment of its antiseptic virtues. He commented upon its use in post-operative wounds following removal of tuberculous bones and joints, as well as in tubercular and simple ulcers of the leg.

Vanverts<sup>5</sup> noticed a decrease in wound supuration, disappearance of foul odor, and the early appearance of healthy granulations. Laurent,<sup>6</sup> in 1909, made a study of the chemical characteristics of zinc peroxide, and concluded that it was the ideal medium by which oxygen could be applied slowly to infected wounds. He believed that soon after its use a detoxification of the poisons produced by bacteria was brought about, and that leukocytic defense was greatly intensified. His observations were upon the effect of zinc peroxide on staphylococcus, streptococcus and the colon bacillus, and no apparent study was made of its action on anaerobic organisms.

All of the earlier authors using zinc peroxide used it in the form of ointment, powder or lotion. They all observed, without study of the bacterial flora, that stimulation of wound healing occurred with an absence of wound odor.

Meleney<sup>7</sup> approached the study of zinc peroxide from the bacteriologic viewpoint, and it is to him we pay homage for bringing this valuable therapeutic agent to our attention in this country. He felt that the offending organisms in many infections that resisted every known therapy were probably anaerobes, or, as he calls them, micro-aerophilic organisms that can be isolated only by anaerobic culture. He isolated a micro-aerophilic hemolytic streptococcus and began his search for a treatment that would liberate oxygen slowly in a wound so infected.

Dr. Hans Clark, professor of biochemistry of the College of Physicians and Surgeons, suggested zinc peroxide as a medicament liberating oxygen slowly with a residuum of zinc oxide. Considerable difficulty was encountered in obtaining a constantly potent preparation,—that is, one which does not remain inert but liberates oxygen. Meleney<sup>8</sup> brought out a simple test to determine the effectiveness of different batches of the powder. A half teaspoonful of the powder is placed in a test tube, which is then filled with water and shaken. A rapid sedimentation occurs in the effective product, and in two or three hours bubbles of oxygen are seen in the precipitate, giving it

the appearance of curdled milk. Meleney<sup>9</sup> found that this liberation of oxygen over a prolonged period had specific effects on wounds containing anaerobic or micro-aerophilic organisms by inhibiting the organisms and then killing them. He also found that the remaining organisms lost their anaerobic and hemolytic properties, leaving the wound as an ordinary, non-hemolytic streptococcus infection which succumbed rapidly to the granular healing process.

Zinc peroxide is a white powder with the consistency of chalk. The manufacturers recommend heating small amounts of the powder in an oven for four hours immediately before use. This is for sterilization, not activation. A very thin suspension of the powder is made by adding distilled water and constantly stirring until a whitewash consistency is reached. The wound is debrided and cleaned of as much necrotic matter as can be removed by irrigations of distilled water, and is dried with cotton applicators. The thin suspension is then injected into every angle of the wound. In the case reported the wound was wide open and could be seen in every part. The undermined skin was raised on applicators and the suspension injected with some force by an aseptic syringe.

The wound should be covered with several layers of fine meshed gauze impregnated with the thin suspension of zinc peroxide. Over this gauze several layers of zinc oxide gauze are placed so that the wound is completely sealed. It is an additional aid to minimal evaporation if the zinc oxide gauze is covered with zinc oxide paste. This dressing is removed twenty-four hours later and the zinc peroxide flushed from the wound with distilled water, removing all particles. The wound is again dried and the dressing reapplied daily until healthy granular areas appear as easily bleeding raw surfaces. Care must be exercised that these granular areas are not disturbed until they have covered a goodly portion of the wound, at which time the dressings of zinc peroxide may be discontinued and the wound treated as a healthy granular surface.

The following case report will illustrate the result after every other endeavor had met with failure.

## CASE REPORT

A white unmarried girl of twenty years was taken to the Jackson Memorial Hospital from a cruise ship that arrived in Miami on October 5, 1938. In June, 1938, her physician in New Jersey had operated on her right great toe for an infection around the nail that had resulted from a chiropody injury. He removed half of the great toe nail, opened down upon the periosteum, and established drainage. Following this procedure the wound continued to drain a purulent material for three months, but by October first it had cleared so that the patient was released to take a cruise to Nassau and Miami.

Prior to this illness the girl had been in excellent health. She had had measles, chicken pox and whooping cough in childhood, and an appendectomy had been performed when she was eight years old. The menstrual history was normal and the girl made her living by working in a bank.

The boat had no more than left the dock in New York when she began to have severe pain in her right groin and a swelling appeared. The ship physician put her to bed with heat to the groin. She had no fever or chills, but the pain became more and more severe. The swelling in the groin grew steadily larger. Her appetite failed and general malaise appeared. I met her at the dock in Miami on October 5, and sent her to the hospital by ambulance. On admission her temperature was 98 F., pulse 120 and respiration 22. General examination was essentially negative aside from her right thigh and foot. The outer half of the great toe nail had been removed, and upon pressure there was tenderness and a serous drainage from the under surface of the remaining nail.

A large mass, hard, red, very tender, and about five inches in diameter occupied the upper inner aspect of the right thigh about four inches distal to the pubis. There was no visible evidence of extension of the infection from the right toe to the groin. A diagnosis of suppurative inguinal adenitis was made.

The blood count on admission was as follows: hemoglobin 84 per cent, erythrocytes 3,860,000, leukocytes 32,700, stab cells 25 per cent, segmented cells 62 per cent, lymphocytes 5 per cent, and monocytes 8 per cent. The Kahn test was negative. The urine was acid, specific gravity 1.035, no albumen, sugar IV, 2.27 per cent; acetone IV and diacetic acid negative. The sugar in the urine was attributed to two infusions of 1000 cc. 5 per cent glucose. A roentgenogram of the right hip, including the entire right side of the pelvis and the upper one-third of the femoral shaft, revealed no evidence of bone pathology.

The patient was taken to the operating room and an incision made over the most prominent part of the swelling and just medial to the large vessels, and creamy pus was encountered. The incision was enlarged, and finger exploration revealed many broken down lymph nodes. A soft catheter was inserted into the bottom of the wound, a Penrose drain placed beside the catheter and the wound left open. The remnant of the right great toe nail was removed by elevation with a forcep. Culture of the pus removed showed a non-hemolytic short chain streptococcus.

Hot wet dressings of boric acid were begun. On the following day sulfanilamide was begun, and she received 485 grains during the next ten days. It was necessary to give her two transfusions of citrated blood because of an anemia that appeared after three days on sulfanilamide. The blood concentration of sulfanilamide was 14.8 mg. per 100 cc. after eight days, and the drug was discontinued on the tenth day.

Two days after admission the urine was free of sugar and acetone, and showed only six to eight pus cells and a few bacteria. The postoperative temperature had dropped to normal in three days. Irrigations with Dakin's solution and continuous hot dressings were used until the ninth day after admission, when the wound became exquisitely tender, with an area of lymphan-



gitis extending upward from the incision to Poupart's ligament. Ninety roentgen units of x-ray were given on the tenth day after admission, with immediate relief of the pain in the skin. Smears taken from day to day showed only a few gram-positive diplococci. Drainage from the wound became scant, and healthy granulations began to appear under the cutaneous edge and in the depth of the wound. Dry dressings were now applied twice daily after flushing the wound with hydrogen peroxide or distilled water. It was felt that healing had advanced far enough to allow her to go to an apartment on Miami Beach, where sunshine and general systemic support could be attained. She was dismissed by ambulance on October 23, eighteen days after admission.

The wound was exposed to direct sunshine for an hour each day after her tolerance to sunshine had been established. Cod liver oil ointment was used as the only dressing.

Six days later the pain returned in increased severity lateral to the healing wound. The skin edges in the incision were curled in, and a dead space from which there was no drainage was found to exist under the skin. The severity of the pain increased with no rise in temperature. The patient was taken to St. Francis Hospital on Miami Beach on October 31, one week from the day she left the city hospital.

On the second admission the urine reaction was alkaline with an occasional pus cell noted. Hemoglobin was 14.89 gm. or 98 per cent, erythrocytes 4,170,000, leukocytes 5,450; segmented cells 61 per cent, stab cells 6 per cent, lymphocytes 28 per cent, eosinophiles 4 per cent, basophiles 1 per cent.

Under cyclopropane anesthesia an incision four inches long was made just lateral to the femoral vessels from the inguinal ligament downward. A necrosis of tissue had taken place under the skin. The whole area was debrided, leaving only a bridge of skin between the original wound and the new incision. There appeared to be no deep extension and the fascia lata was not opened. A specimen was excised from the necrotic area for culture, smears were made, and the wound lightly packed with iodoform gauze. Upon the patient's return to her room, continuous warm wet dressings of saturated boric acid solution were begun. Culture of the tissue removed at operation gave a pure culture of staphylococcus albus on plain and blood agar. Smears from the wound discharge showed a gram positive diplococcus in short chains.

On November 3, the boric acid dressings were discontinued, and continuous Dakin's solution was begun. Because of pain this had to be discontinued two days later; aqueous gentian violet, applied topically each day, was substituted. The wound base remained a dirty gray with a watery, cloudy discharge. After consultation on November 23, it was again decided to try sulfanilamide, and during the next twenty-one days 925 grains of the drug were given. The patient underwent six transfusions, not because of anemia, but for general support. The blood concentration of sulfanilamide reached a peak of 8.6 mg. on December 1.

The wound continued to be exquisitely painful, and an aqueous solution of 1 per cent eucupin hydrochloride was tried, with no relief. A search for Donovan bodies was fruitless. Because of a persistent staphylococcus culture, staphylococcal toxoid injections were begun and continued in increasing doses from November 9 to November 24.

Up to November 24, the wound had not changed in appearance for three weeks. The skin edges were undermined, the base and sides of the wound glistening and gray in color. A pure culture of hemolytic streptococci was obtained by anaerobic culture on November 23.

On November 25, zinc peroxide treatment was begun and continued daily for seven days. On the seventh day, the wound depth was filled with healthy, easily bleeding granulations, and the undermined skin edges had

begun to fasten themselves to subcutaneous tissue. Pain had completely left the wound. Each day the skin edges were gently pulled closer together with flamed tape, and a light balsam of Peru dressing applied.

On December 14 the patient was dismissed from the hospital using crutches. One week later she left by train for her home in New Jersey with a very superficial defect in skin approximation. A letter from her two weeks later assured me the wound had completely healed.

#### SUMMARY

A case of chronic undermining infection due to an anaerobic hemolytic streptococcus is presented.

Anaerobic cultures should be made routinely in infections that are not responsive to usual therapeutic measures. I feel that sulfanilamide was not responsible for the final result in this case, because use of the drug did not prove beneficial prior to the use of zinc peroxide.

Zinc peroxide should be used in wounds contaminated with anaerobic, micro-aerophilic or susceptible aerobic organisms as an initial treatment, and not as a last resort. The economic insult to the patient in the described case could have been minimized if early therapy with zinc peroxide had been instituted.

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## SPOROTRICHOSIS

## CASE REPORT

WILLIAM M. DAVIS, M. D.  
St. Petersburg

W. H. was first seen on December 5, 1938, because of a small infected wound on the back of the proximal joint of the middle finger which had existed for 3 or 4 days and had been caused by the prick of a thorn while he was working as a horticulturist. Ordinary surgical procedures were followed without any improvement. In fact, the infection spread under the epidermis, the finger swelled, and there were discrete superficial pustules like a carbuncle. After about a week, hard painful superficial nodules appeared, first on the anterior surface of the arm just above the elbow, successively down the dorsum of the forearm and hand to form an almost continuous chain. These gradually softened, increased in size, and became fluctuating. New ones appeared from time to time but none were larger than a silver dime and all were quite superficial. There was no involvement of the deep lymphatics, epitrochlear or axillary glands and the general health of the patient was not interfered with. The condition was due to infection with *Sporothrix* and a diagnosis should be made on clinical findings. The treatment consists of potassium iodide, which is specific.

The literature states that at times the initial lesion may entirely clear up and that at a subsequent date, even as late as three months, the nodules may appear. The lesions may vary in size from that of a pea to that of an orange; they may soften and break

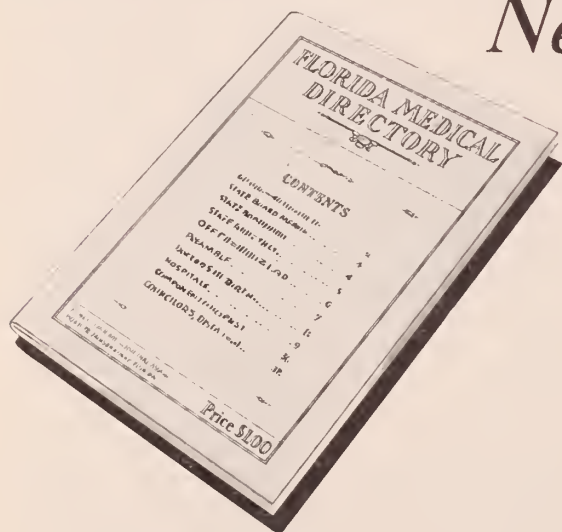
through the skin and gradually undergo involution or increase in size with fistulous openings. Incision increases their growth rather than promotes resolution. Occasionally the ulcer enlarges and takes on a fungous papillomatous growth, producing a lesion resembling tuberculosis verrucosa cutis. The lesions are indolent but progressive and may become irregularly disseminated over various parts of the body.

As a rule, the organisms cannot be seen in the fresh discharge or in sections but they are aerobic and grow on ordinary media and then are easily identified.

The condition must be differentiated from syphilis, tuberculosis, and occasionally blastomycosis. The latter, however, is characteristically a slowly enlarging, indolent, flat, wart-like or crusted papule. Culture, of course, is conclusive and in view of the fact that potassium iodide is specific, an early diagnosis is desirable.

342-1st Ave. N.

Read before the Pinellas County Medical Society,  
January 6, 1939.



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**ANNUAL CONVENTION, TAMPA**

In your next Journal, which will be the April number, will be found a complete program for the Sixty-seventh Annual Meeting of the Florida Medical Association. It will include an outline of the elaborate plans for entertainment which have been made by the Hillsborough County Medical Society under the leadership of Dr. J. R. Boling, General Chairman. This society, which has not been host to the Association for twelve years, is looking forward to a record attendance, based on the facts that the membership of the Association is now well over 1,300, that 32 technical exhibit spaces have been sold, that more special groups than ever before will meet in conjunction with the State Association, and for the further fact that Tampa is a delightful place in which to hold a convention.

Many doctors will undoubtedly arrive in Tampa on Sunday as the Railway Surgeons will hold a stag dinner that evening and as eight groups of specialists will meet Monday forenoon: the Railway Surgeons, Florida Pediatric Society, Florida Association of Industrial Surgeons, Florida Radiological Society, Florida Internists' Society, Florida Society of Ophthalmology and Otolaryngology,

Florida Society of Dermatology and Syphilology, and the Health Officers Section of the Florida Public Health Association.

President Robinson has invited Dr. B. R. Kirklin of the Mayo Clinic, Rochester, to be guest speaker. His address is scheduled for Tuesday evening, April 30, in the Palm Room of the Tampa Terrace Hotel.

The first meeting of the House of Delegates will convene at 1:30 p. m., Monday, April 29. Each component society's representation in the House will be in the proportion of one delegate for each 20 members who have paid 1940 dues. Thirty days in advance of the annual meeting, secretaries of county medical societies are required to forward 1940 dues of their members to the secretary of the State Association.

The House of Delegates is the State Association's legislative body. The volume of business gravitating to the House has increased from year to year to such an extent that it has become necessary to relieve it of some of its details. To facilitate the handling of reports, resolutions, etc., there will be three reference committees at the meeting this year, subject to the approval of the House of Delegates. All reports and resolutions read at the first meeting of the House will be referred to one of these committees. Each reference committee will hold a meeting prior to the second meeting of the House of Delegates, the time of such meeting to be announced so that all members interested in reports or resolutions may have an opportunity to attend and enter into the discussion. The chairman of each reference committee will make recommendations to the second meeting of the House of Delegates and will be able to give definite reasons for such recommendations on the questions involved. This procedure will eliminate unnecessary discussion on the floor of the House and give members a better opportunity to have their suggestions analyzed before final action is taken. By dividing the work among three reference committees, much more time than heretofore can be devoted to each item of business. It is believed that this plan will result not only in increased efficiency but in the utilizing of more of the splendid recommendations contained in annual reports of the Association's committees. The personnel of



the three reference committees will be found in your April Journal.

The first general session is scheduled for 4:30 Monday afternoon. At this session the annual address of the State Association's president will be given, followed by the annual report of the secretary-treasurer-editor and managing director. The first scientific assembly, consisting of three papers, will be held at 7 p. m., Monday. Tuesday forenoon and afternoon will be devoted to scientific papers, with the second meeting of the House of Delegates on Tuesday at 4:30 p. m. A stag smoker is scheduled for Monday evening at 9 o'clock and the Association dinner, Tuesday evening at 7:30.

As a record attendance is anticipated, it is suggested that those who desire rooms at the headquarters hotel make their reservations as early as possible.

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#### CLINICAL MATERIAL AVAILABLE FOR JUNE SHORT COURSE

Interest in graduate education has been increasing steadily throughout the United States during the past decade. The American Medical Association has done much to foster courses and institutes designed to bring to the busy doctor a concentrated series of lectures and clinics in a short period, giving him instruction comparable to that of the best post-graduate schools of the country. The Florida Medical Association has long been in the vanguard of the graduate education campaign with its annual Short Course.

The Medical Postgraduate Course Committee has consistently tried to bring the best quality of graduate medical education to the doctors of the state, attempting to answer the demands as well as the needs of the Florida physicians. To this end a questionnaire has been submitted at each district meeting, and the response has been very gratifying to the Committee. Most of the doctors have endorsed the work of the Committee, and many constructive criticisms have been received, which will be incorporated into the plans for future courses. Many minor experiments have been tried since the institution of the Short Course eight years ago, but the general plan originally worked out has been followed, namely, the organization of lectures and clinics along the general divi-

sions of Medicine, Surgery, Pediatrics, etc., with occasional lectures in the more restricted specialties. It is felt that by so doing, the needs of a larger proportion of the physicians attending may be served.

The outline of the Eighth Graduate Short Course, to be held in Jacksonville June 24-29, indicates that it will be the best course yet given. The program is in preparation and will shortly be published in the *Journal*. This year, for the first time, clinical material will be available for demonstration, through the courtesy of the Duval County Hospital. As there is always a wealth of material at this institution, there should be no lack of interesting cases for clinic use. The Committee feels that these demonstrations will materially increase the value of the course.

The meetings this year will be held in an air-conditioned hotel, assuring the comfort of all who attend. Announcement of the place of meeting will be made when the program is published.

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#### WHAT IS THE WOMEN'S FIELD ARMY ?

"Early Cancer is Curable. Fight it with knowledge"—This is the slogan of the Women's Field Army, the volunteer educational organization that is being built throughout the country under the auspices of the American Society for the Control of Cancer. Under the direction of the state commander, Mrs. A. Malcolm Smith of Tampa, local units of the Field Army are formed in cities, towns and counties. These units are centers for the spread of information on cancer and are directly under the supervision of the local cancer committees of the county medical societies.

The work of the Field Army in Florida has been divided into six districts to conform to the districts of the Medical Association. Each district is supervised by a vice-commander and small groups of counties in the district, by majors. The campaign in each county is organized by a captain and her lieutenants. The State Commander is directly responsible to the cancer committee of the Florida Medical Association and each vice-commander to the committee member in her district.

It is urged that each member of the Florida Medical Association cooperate to the fullest extent in helping these volunteer workers in

their educational campaign. An enlightened public opinion can do much to bring early cancer cases to diagnosis and treatment.

The Army is beginning its fourth annual enlistment in April. Both men and women may enroll and the fee is one dollar. Seventy per cent of the enrollment fee will be spent in the state under the direction of the state executive committee and thirty per cent will be returned to the American Society for the Control of Cancer. Let us meet this responsibility so that Florida may take her place among the states of low cancer mortality.

#### NEWSPAPER EDITORIAL COMMENT

The Jacksonville Journal, which on several previous occasions has published editorials commending the medical profession, has again expressed a viewpoint which is timely. This editorial, which appeared in the February 3 issue of this newspaper, is quoted:

##### DOCTORS COST

It has always been pretty generally known that it costs more to turn out an acceptable physician and surgeon than it requires to certify any other specialist. Not until the recent publication of an exhaustive survey on medical education costs between 1934 and 1939 have doctors been able to put their fingers on real figures.

The research committee of the American Medical Association discovered that the cost per credit hour for a medical student was \$26.96 compared to the next highest, \$15.87 for dentistry. The cost for law courses averaged \$11.05, for teaching, only \$4.06.

Embryo doctors must have expensive equipment with which to practice. They must have the real thing. They can't play with theory. The average cost of education borne by the student himself is calculated at 55.3 per cent of the total. The rest is taken care of by endowments, payments for services, scholarships, and gifts.

You might bear this in mind the next time the family doctor sends you a polite bill for services.

#### AMERICAN PHYSICIANS' ART ASSOCIATION

The American Physicians' Art Association composed of over eight hundred physicians in the United States, Canada and Hawaii who follow some form of Fine or Applied Art as an avocation, will hold the next annual art show at the Belmont-Plaza Hotel, New York City, June 10 to 14, inclusive. This exhibit is held in conjunction with the American Medical Association Convention to be held at the same time in the vicinity of the Belmont-Plaza. All physicians in active practice or retired who have an art hobby including photography are cordially invited to participate in the New York Exhibit.

To become a member of this Art Association a physician may join by mailing a check for one dollar to the Treasurer, Dr. R. W. Burlingame, San Francisco County Hospital, San Francisco, Calif., and briefly stating what art medium he follows.

For detailed information kindly write to the Executive Secretary, Dr. F. H. Redewill, 526 Flood Building, San Francisco, Calif.

#### BIRTHS

Dr. and Mrs. L. Paul Foster of Orlando announce the birth of a daughter, Barbara Jean, on January 26, 1940.

\* \* \*

Dr. and Mrs. I. J. Strumpf of Jacksonville announce the birth of a son, Robert Ewing, on February 23.

\* \* \*

Dr. and Mrs. Maurice E. Heck of Miami announce the birth of a daughter, Beverly Lynn, on January 17.

#### STATE NEWS ITEMS

Dr. Francis W. Glenn has opened offices at 1006 Huntington Building, Miami. His practice is limited to orthopedic surgery.

\* \* \*

Three appointments were recently made to the Staff of the Duval County Hospital, Jacksonville, as follows: Dr. Raymond H. King, chief of the Department of Otorhinolaryngology; F. G. King, Associate in Anesthesia; and W. H. Brooks, Associate in Urology.

#### FRANK E. KAUFFMAN

Dr. Frank E. Kauffman, 71, for fifteen years a practicing physician in Clearwater, died January 29, after an illness of several months.

He is survived by his widow, Mrs. Rose J. Kauffman; by two daughters, Mrs. Frank Lee, Tulsa, Okla., and Mrs. D'Arcy McNickle of Silver Springs, Md.

Doctor Kauffman came to Clearwater in 1925 from Lake City, Iowa and for several years was associated with Dr. N. E. Mighell.

At one time he was chief of staff of the Morton F. Plant Hospital.

Before he studied medicine, Doctor Kauffman was a member of the well known Columbian Guards, semi-military organization which policed the Columbian Exposition in Chicago in 1892.

Doctor Kauffman was a Mason and held his membership in his former home town, Lake City, Iowa.



### C. E. TUMLIN

The death of Dr. C. E. Tumlin, a charter member of the Florida Association of Industrial Surgeons, was deplored by that body in the following Resolutions which were recently adopted:

WHEREAS, the Florida Association of Industrial Surgeons has suffered a loss in the sudden and untimely death of Dr. C. E. Tumlin, our first president who was largely responsible for the formation of our organization, and

WHEREAS, Dr. Tumlin was a faithful worker, much interested in our efforts to develop a better understanding of the handling of employers' liability cases so that we may be better able to cooperate with the carrier, the employer, and the employee, in handling same.

He gave cheerfully of his time and talent to every cause intended to strengthen and benefit the Association, having always been a true disciple of the principles of organized medicine, always maintaining the highest standard of ethical relationship.

RESOLVED, That in the death of Dr. Tumlin the Association has lost a member whose place will be hard to fill, whose active interest will be sadly missed, whose devotion to its best interests has been largely responsible for its development and influence in the establishment of the better understanding of the industrial cases.

RESOLVED, That we deplore the loss of Dr. Tumlin and feel the loss of this member very deeply, that each member of the Association is grieved, and extend to his family our deepest sympathy.

BE IT FURTHER RESOLVED, That the Florida Association of Industrial Surgeons offers condolence to the bereaved family in this hour of sadness over their departed member and that a copy of these resolutions be sent to his bereaved widow and family and the State Medical Journal.

Harrison Walker,  
Frederick Oetjen,  
A. M. Bidwell,  
Committee

FOR SALE: Rose Short Wave Diatherm, Aloe S. W. Diatherm, portable. Both practically new. Wantz Victor X-Ray 60 Ma. remodeled with timer. Each \$125.00 delivered in South Florida. S. A. Winsor, M. D., Box 6, Pompano, Florida.

## COMPONENT COUNTY SOCIETIES

### DADE COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Dade County Medical Society was held in the Sunshine Room of the Florida Power and Light Building, Miami, Tuesday evening, February 6. Dr. Joseph S. Stewart, president, presided.

Dr. Bradley M. Patton, Head of the Department of Anatomy, University of Michigan Medical School, guest speaker, presented a remarkable micro-moving picture of living embryos showing the development of the circulatory system.

Dr. Tinsley Harrison of Vanderbilt University was also a guest at this meeting and spoke on recent advances in the fundamental concepts of the cause and treatment of various hypertensive syndromes.

\* \* \*

### DESOTO-HARDEE-HIGHLANDS-

#### CHARLOTTE-GLADES COUNTY MEDICAL SOCIETY

The doctors of Wauchula were hosts to the members of the DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society at a dinner meeting held at the Hotel Simmons on February 13. Attending this meeting were Drs. H. V. Weems, H. E. Boorum and L. W. Martin of Sebring; Chas. J. Collins, Orlando; I. W. Chandler, Avon Park; G. F. Highsmith, Arcadia; A. T. Eide, Lake Placid, and M. C. Kayton of Wauchula.

\* \* \*

### DUVAL COUNTY MEDICAL SOCIETY

The February meeting of the Duval County Medical Society was held on the evening of the 6th in the Library of the State Board of Health Building. The following papers constituted the scientific program:

"Bone and Joint Infections in Children" by J. F. Lovejoy; discussed by F. L. Fort.  
"Foci of Bone and Joint Infections,"  
by Luther W. Holloway.

A business meeting followed, after which refreshments were served.

\* \* \*

### FRANKLIN-GULF COUNTY MEDICAL SOCIETY

Dr. Thos. Meriwether of Wewahitchka was host to the members of the Franklin-Gulf County Medical Society at a meeting held at the Community Club House on the evening of February 16.

Dr. John T. Ellis of Dothan, Ala., who was guest speaker, presented a paper on "Fractures of the Spine," which was illustrated.

It was decided to hold the next meeting on March 21 at Carrabelle at which time Dr. Chapman Dykes will be host.

The Franklin-Gulf County Medical Society, the "youngest" of the Association, is on the honor roll of 100% paid societies for 1940. Congratulations, Franklin-Gulf County Medical Society.

PASCO-HERNANDO-CITRUS COUNTY  
MEDICAL SOCIETY

The regular meeting of the Pasco-Hernando-Citrus County Medical Society was held February 8 at Brooksville, on invitation of Dr. G. R. Creekmore. A grilled steak dinner was served at the Tangerine Hotel, followed by a scientific program in the hotel parlor. A round table discussion was featured on pneumonia cases reported, which proved to be very interesting. Dr. S. C. Harvard gave a case report of tetanus, which was well received.

Dr. W. W. Jones invited the society to hold its next meeting with him in Dade City. The secretary announced that the society is now legally incorporated and the papers of incorporation recorded with the Clerk of the Circuit Court of Hernando County.

Members present at this meeting were: Drs. J. T. Bradshaw, E. H. Brown, G. R. Creekmore, S. C. Harvard, W. W. Jones, W. B. Moon, and W. H. Walters.

\* \* \*

## PINELLAS COUNTY MEDICAL SOCIETY

The Pinellas County Medical Society met at the Shrine Club, St. Petersburg, February 2 at 6 p. m. for refreshments, dinner and a scientific program. Dr. J. A. Herring presided.

Dr. E. B. Campbell reported two cases of frozen toes during the recent "exceptional weather" in Florida. Dr. M. O. McNay presented a paper on "Comparison of Roentgenologic and Operative Findings in 78 Caldwell-Luc Operations" which was discussed by Doctors Nickle, Feaster, Stoll, Murphy, and Herring. Dr. G. Timberlake discussed several urological diseases and illustrated his talk with lantern slides.

Guests present at this meeting were: Drs. C. L. Williams of Linesville, Pa.; E. R. Miner, McComb, Ill.; H. R. Miner, Falls City, Nebr.; J. F. Kennedy, Augusta, Me.; and G. E. Hafford, D. K. McQweer, G. R. Pray, G. E. Winter of Michigan.

\* \* \*

ST. LUCIE-OKEECHOBEE-INDIAN RIVER-  
MARTIN COUNTY MEDICAL SOCIETY

At the annual meeting of the St. Lucie-Okeechobee - Indian River - Martin County Medical Society held at the Ft. Pierce Memorial Hospital on January 25, the following

officers were chosen: President, F. A. Gowdy, Ft. Pierce; vice president, J. B. Kollar, Vero Beach; secretary-treasurer, Adrian M. Sample, Ft. Pierce. Dr. M. D. Council of Ft. Pierce was named delegate to the annual meeting of the State Association with Dr. R. C. Boothe of Ft. Pierce, alternate.

\* \* \*

## VOLUSIA COUNTY MEDICAL SOCIETY

Druggists of Daytona Beach were hosts to the members of the Volusia County Medical Society at an informal stag reception and steak supper at the Country Club on the evening of January 24. Dr. Joseph H. Rutter won first prize offered by the druggists for the best anecdote narrated by one of the guests. Dr. W. L. Jennings was runnerup.

W. Maxwell Hankins, former president of the National Association of Boards of Pharmacy and former member of the state board, talked on the history of pharmacy and the improvement of its practice.

\* \* \*

WASHINGTON-HOLMES COUNTY MEDICAL  
SOCIETY

On Thursday evening, February 29, members of the Washington-Holmes County Medical Society and members of the Medical Profession in Northwest Florida and Dothan, Alabama, were entertained at a bird supper by Dr. George W. Carter of Chipley, Fla.

The scientific program, which was well received, was as follows:

"Sulfapyridine and Pneumonia," T. K. McFatter, Dothan, Ala.

"Organized Medicine," J. Sam Turberville, Century.

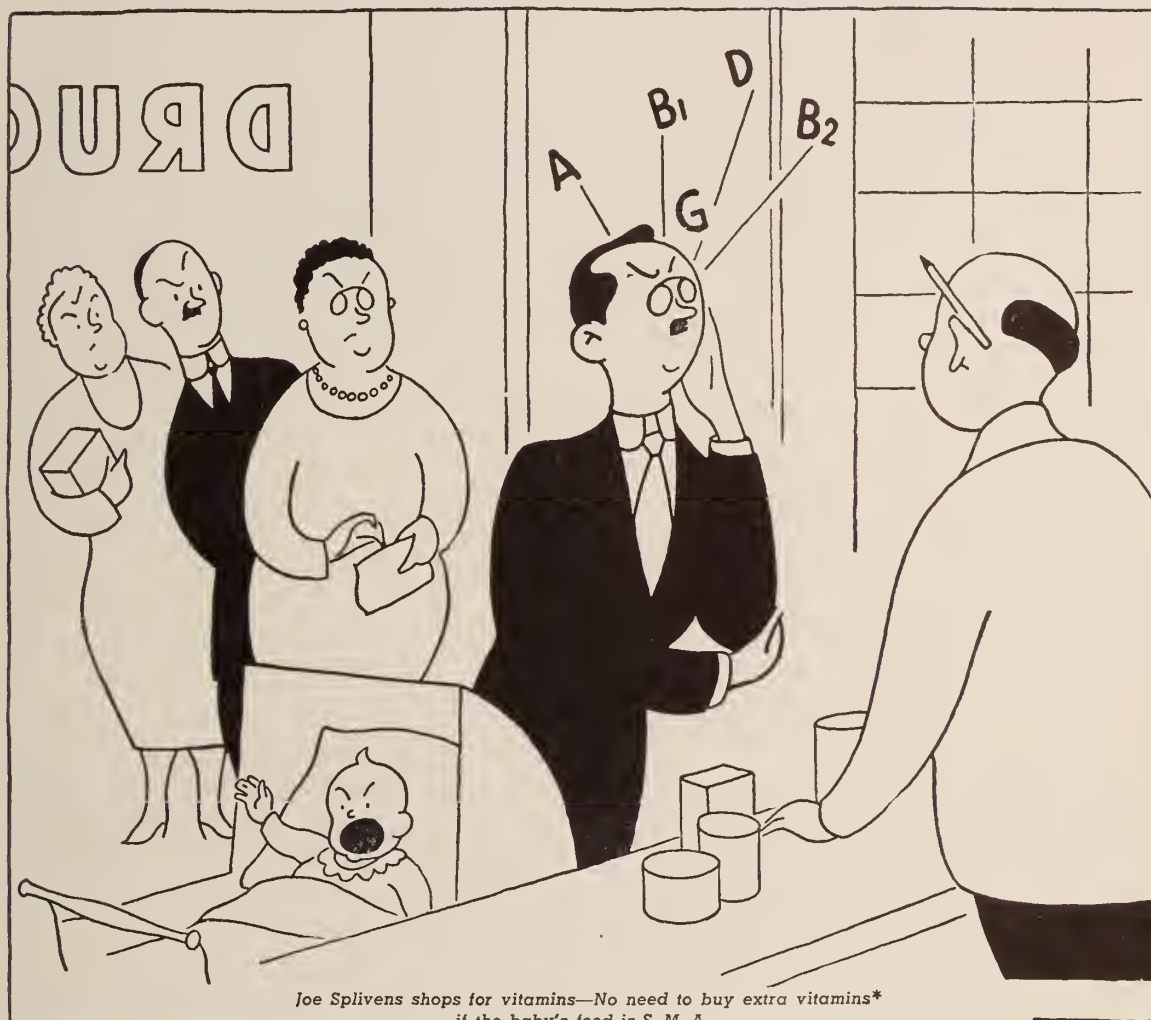
"Ethics and Medicine," John Keyton, Dothan, Ala.

A very enjoyable feature of the evening was the presentation of a series of lantern slides by Dr. John T. Ellis of Dothan, Ala., and last but not least was a short "pep" talk by Dr. A. E. Conter of Apalachicola.

The following invited guests and members attended: J. A. Campbell, John T. Ellis, John A. Keyton, T. K. McFatter, Arthur Mazyck, and Earle F. Moody, Dothan, Ala.; J. S. Turberville and J. I. Turberville, Century; N. A. Baltzell, D. A. McKinnon, C. D. Whitaker, Marianna; M. J. Lingo, A. H. Lisenby, W. C. Roberts, Panama City; Her-



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### ABSTRACT DEPARTMENT

*Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.*

**Mesenteric Cysts, SNYDER, J. W. Miami, South. Surgeon, 8: 240-248 (June), 1939.**

Mesenteric cysts are extremely rare, the total number reported in the literature being about three hundred, the incidence from reported studies being about one per hundred thousand in hospital admissions. Very few have been diagnosed preoperatively.

The origin of these cysts is variable though most of them seem to be either embryonic cell rests from the Wolffian body, or due to embryologic defects in the formation of lymph nodes, or in the case of chylous cysts, obstruction to the lacteals may be responsible.

These cysts may be classified on an anatomic basis as follows: (a) simple cysts, (b) chylous cysts, (c) cystic dermoids and teratomas, (d) enterocystomas, (e) parasitic cysts, hyatid or echinococcus, (f) traumatic or infectious.

There is no characteristic symptom complex which will lead to an accurate diagnosis in these cases, and the only treatment is surgical, though not all cysts can be completely removed, because simple enucleation is not always feasible.

The author reports a case in a 32 year old male, in whom a cyst arising by a pedicle close to the first part of the jejunum was completely removed.

**The Value and Significance of the Tuberculin Test, LOCIE, ARTHUR J., Jacksonville, Ann. Int. Med. 13: 255-260 (Aug.) 1939.**

Tuberculin testing is a routine procedure in all branches of medicine, and should be employed in mass testing of groups to discover susceptible and active individuals. A positive tuberculin test tells us that tubercle

bacilli have invaded the body, though it does not mean that active or destructive disease is present.

The most commonly used test is the Mantoux, using dilutions of old tuberculin, and more recently the purified protein derivative of tuberculin, which comes in two dilutions. The important limitation of purified protein derivative is the fact that it must be kept on ice after being put into solution and can be kept only a few days, after which its potency is gone.

A positive tuberculin test is a red erythematous area on the arm at the site of injection, intradermally as in the Schick test. Erythema, alone does not constitute positivity. There must be at least 5 mm. of induration with the erythema before one can designate a reaction as positive. The author discusses the significance of positive reaction.

### ADVERTISERS' NOTES

#### SHOULD COD LIVER OIL BE FLAVORED?

It is a well known fact that young infants shy at aromatics. Older patients often tire of flavored medications to the point where the flavoring itself becomes repellent. This is particularly true if the flavoring is of a volatile nature or "repeats" hours after being ingested. Physicians have frequently used the terms "fresh," "natural," "sweet," and "nutlike," in commenting upon the fine flavor of Mead's Cod Liver Oil. They find that most patients prefer an unflavored oil when it is as pure as Mead's.

Physicians who look with disfavor upon self-medication by laymen are interested to know that Mead's is one Cod Liver Oil that is not advertised to the public and that carries no dosage directions on carton, bottle or circular. Mead Johnson & Company, Evansville, Indiana, U. S. A., will be glad to send samples and literature to physicians only.

#### THE AMEBIASIS PROBLEM

A study made by the U. S. Medical Corps, covering every section of the United States, shows that between 5 and 10 percent of the people probably harbor *Endamoeba histolytica* (Kagy, Bull. Hyg., 14: 746, 1939). Clinically, the persons infected may be divided into four groups, in which symptoms vary from none appreciable (so-called healthy carriers) to those accompanying acute or chronic amebic dysentery. Food handling is held to be the most important mode of transmission, but dubious water supplies, night soil used as fertilizer, and fly droppings are other factors which may result in infection.

Carbarsone, Lilly (p-Carbamino Phenyl-arsonic Acid) is amebicidal in vitro at 1:4,000 and has a marked degree of efficacy in amebiasis in doses which, if conservatively utilized, are relatively non-toxic. Its administration is followed by symptomatic relief, clinical improvement, and consistent failure to find cysts or motile amebas in the stools on very frequent and careful examinations. Vaginal suppositories containing 2 grains of Carbarsone, Lilly, have given very good results in the treatment of *Trichomonas vaginalis* vaginitis in the hands of numerous observers.





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\*"Treatment of Acute Anterior Urethritis with Silver Picrate," Knight and Shelanski, AMERICAN JOURNAL  
OF SYPHILIS, GONORRHEA AND VENEREAL DISEASES, Vol. 23, No. 2, pages 201-206, March, 1939.

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## CONVENTIONS

Florida Medical Assn...April 29-May 1, 1940

American Medical Assn...June 10-14, 1940

\* \* \*

Have you made your hotel reservation for the 18th Annual Convention of the Woman's Auxiliary to the American Medical Association which will be held in New York City, June 10 to 14, 1940?

The headquarters are at the Hotel Pennsylvania and we are sure you will not want to miss this convention which promises to be an outstanding one. *Mail your reservation today* to Dr. Peter Irving, Housing Bureau, Room 1036, 233 Broadway, New York City.

\* \* \*

Your President is very anxious for a good attendance at the meeting of the Auxiliary to be held at the Tampa Terrace Hotel, Tampa, April 30 at 10 a. m.

Kindly have all reports for the State Meeting typewritten and do not forget to elect your delegates and alternates.

\* \* \*

## COUNTY AUXILIARIES

### DADE COUNTY

The Auxiliary to the Dade County Medical Association anticipates an interesting, busy spring. Members are looking forward to the state convention in Tampa, April 29 through May 1, when Mrs. Rollo Packard, Chicago, national president, will be guest of honor. Mrs. Charles Corn, Greenville, S. C., presi-

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dent of the Southern Medical Association Auxiliary, also will attend.

Plans for this meeting were discussed at a board and luncheon meeting Monday, February 12, 1940, at the Antilla Hotel by Mrs. Lawrence C. Ingram, state president who was guest speaker for the day.

\* \* \*

#### BROWARD COUNTY

The Broward County Medical Auxiliary held a covered dish luncheon meeting, February 13, 1940, at the home of Mrs. Leigh F. Robinson, in honor of Mrs. L. C. Ingram of Orlando, president of the Woman's Auxiliary to the Florida Medical Association. Mrs. Ingram was accompanied by her guest, Mrs. A. E. Dixon, also of Orlando.

Mrs. John Allen Johnston reported on the outcome of the annual sale of Tuberculosis Christmas seals, a project which is sponsored in this county by the local Medical Auxiliary. This year's sale was the most successful ever conducted in Broward County, she said.

The meeting was then turned over to Mrs. Ingram, who reported on various projects undertaken by other auxiliaries in the state. Throughout the state this year, the auxiliaries have tried to stress public education through the Public Health Division Department.

At the last meeting of the Broward County Medical Auxiliary, the following resolutions were passed in memory of:

#### VIRGINIA HANSEN SORY Past Treasurer

WHEREAS, Virginia Hansen Sory was one of the members of the Woman's Auxiliary to the Florida Medical Association, and was our past treasurer,

WHEREAS, a loving mother, a faithful wife, and an indefatigable worker in our ranks has gone to her reward, whose place will be vacant, but whose memory will be an ever present inspiration to the workers of our organization,

THEREFORE, Be It Resolved, that we adopt these resolutions, and a copy be spread on our book of minutes, and that the secretary be instructed to present a copy to her bereaved family.

(Signed)

(President) Mrs. Rupert H. Stovall  
Mrs. J. W. McMurray  
Mrs. M. N. Camp.

\* \* \*

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**FRACTURES & TRAUMATIC SURGERY**—Ten Day Intensive Course starting April 8, 1940. Informal Course every week.

**GYNECOLOGY**—Two Weeks' Course April 22, 1940. One Week Personal Course Vaginal Approach to Pelvic Surgery, April 8, 1940.

**OBSTETRICS**—Two Weeks' Course April 8, 1940. Informal Course every week.

**OTOLARYNGOLOGY**—Two Weeks' Course starting April 8, 1940. Informal Course every week.

**OPHTHALMOLOGY**—Two Weeks' Course starting April 22, 1940. Informal Course every week.

**CYSTOSCOPY**—Ten Day Practical Course rotary every two weeks. One Month and Two Weeks' Courses in Urology every two weeks.

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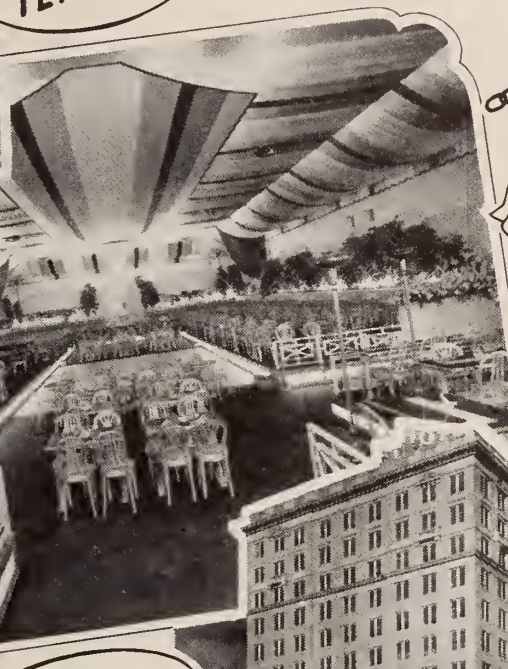
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in regard to our duties as individual auxiliaries of the state.

As stated by our National Constitution the first object of the women's auxiliary is "through its members to extend the aims of the Medical Profession to all organizations which look to the advancement of health education."

The Department of Public Relations will be betraying its trust to the public if it fails in its duty to provide authentic information on the disadvantages which will accrue from systems of managed medicine. It will betray its trust to the medical profession if it fails to present the attitude of the profession on the national health issue. Our duty is clearly defined; how, then, shall we proceed?

A Public Relation program should be so planned as to:

- (1) Create good will for an institution.
- (2) Build a public opinion toward that institution which is correctly informed as to aims.
- (3) Produce confidence in the integrity and ability of that institution to fulfill its obligation to the community in which it functions.

In directing a public relation program certain rules of conduct should be constantly observed.

- (1) Be tolerant and fair.
- (2) Be rational and honest.
- (3) Be tactful.

An unfair irrational and unduly aggressive attitude can destroy the best planned program.

In harmony with the general principles for program building, the Public Relations Committee of the Women's Auxiliary should have two objectives, which may be stated as follows:

- (1) To acquaint the public with the means of acquiring authentic information on health.
- (2) To present the attitude and aims of the American Medical Association on the national health issues.

The first objective is presented in our hand book (page seven) and abundance of material may be listed in part as follows:

- (1) Literature on health from the A. M. A.
- (2) Literature for the laity from National Department of Health Education, A. M. A.
- (3) Sample copies of Hygeia from Hygeia chairman.
- (4) Programs provided by National and State Program Chairman.
- (5) Literature from the National Press Chairman.
- (6) Speakers on Health provided by state and county medical speaker's bureaus.
- (7) Exhibits on health provided by the A. M. A. or by local auxiliary units.
- (8) Radio programs on health by the A. M. A. Education Department and those sponsored by local Medical Societies.
- (9) Educational films and lantern slides, provided by the A. M. A.

The second objective has grown out of social and economic movements which have produced propaganda



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for socialized medicine. It is our business to present the attitude of the American Medical Association on these issues.

To accomplish the objective, we should plan carefully to disseminate information on:

- (1) The disadvantages which may accrue from the socialization of medicine.
- (2) The attitude of the American Medical Association toward the provisions of the Wagner Health Bill. Our efforts in this direction should be increased.

*Important:* All program work must be submitted to the State Advisory Council and to the State Chairman for approval.

The incoming county public relations chairmen should be urged to start their work immediately.

Please write to me for any aid desired. Suggestions from you which will help us accomplish the results desired will be most welcome.

Very sincerely yours,

Jane E. Maines (Mrs. John E.)

State Public Relations Chairman.

1207 West Boulevard,  
Gainesville, Florida.

### BOOKS RECEIVED

*Acknowledgment of books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review, as expedient.*

**THE ART OF ANESTHESIA.** Sixth Edition Revised. By PALUEL J. FLAGG, M. D., Visiting Anaesthetist to Manhattan Eye and Ear Hospital; Consulting Anaesthetist to St. Vincent's Hospital, New York, N. Y.; also to the Woman's Hospital, Sea View Hospital, Jamaica Hospital, Mount Vernon Hospital, Flushing Hospital, Mary Immaculate Hospital, St. Mary's Hospital, Far Rockaway, N. Y.; Nassau Hospital, L. I.; Director of Pneumatology, World's Fair; and Chairman of Committee on Asphyxia of the American Medical Association. The first part of this volume, comprising 14 chapters, bears upon the classification of anesthesia, its characteristic signs and its administration by the various methods ordinarily employed: general, local, and regional block. The 18 chapters of the second part of the book deal with factors incidental to the actual administration of the anesthetic, new agents and methods. Fabrikoid. Pp. 491, with 161 illustrations. Philadelphia: J. B. Lippincott Co., 1939.

**THE VITAMINS.** A symposium arranged under the auspices of the Council on Pharmacy and Chemistry and the Council on Foods of the American Medical Association. So much information has become available about the vitamins that it is difficult even for experts to keep up with the literature. The present volume is a welcome compendium of authoritative information about these accessory food factors. There are discussions of the chemistry, physiology, pathology, pharmacology and therapeutics, methods of assay, food sources and human requirements of each of the important vitamins. The volume is composed of 31 chapters written by experts, and should prove to be indispensable for the library of every physician. Imitation leather. Pp. 637. Price \$1.50 postpaid. Chicago: American Medical Association, 1939.



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## COMPONENT SOCIETIES BY DISTRICTS — FLORIDA MEDICAL ASSOCIATION

| Districts                                                 | COUNTY SOCIETIES                         | PRESIDENT                                                           | SECRETARY                                                          | MEETING DATE                                                           | COUNCILOR<br>and Counties Not Included in First Column | Members |      |
|-----------------------------------------------------------|------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|---------|------|
|                                                           |                                          |                                                                     |                                                                    |                                                                        |                                                        | Total   | Paid |
| Northwest District (A)<br>Pensacola<br>Oct. 5, 1940       | Bay                                      | Amsia H. Lisenby, M.D.<br>Panama City                               | William C. Roberts, M.D.<br>Panama City                            |                                                                        | A-1-'40<br>Carol C. Webb, M.D.<br>Pensacola            | 11      |      |
|                                                           | Escambia                                 | Sidney G. Kennady, M.D.<br>511 American Nat. Bk. Bldg.<br>Pensacola | W. E. Tugwell, M.D.<br>Box 860<br>Pensacola                        | 2nd Tuesday<br>8:00 P. M.                                              |                                                        | 43      |      |
|                                                           | Walton-Okaloosa                          | A. G. Williams, M.D.<br>Lakewood                                    | R. B. Spires, M.D.<br>DeFuniak Springs                             | 3rd Thursday<br>8:00 P. M.                                             |                                                        | 6       | 100% |
|                                                           | Washington-Holmes                        | R. H. Segrest, M.D.<br>Bonifay                                      | L. H. Paul, M.D.<br>Bonifay                                        |                                                                        | Santa Rosa                                             | 8       |      |
|                                                           | Franklin-Gulf                            | Thos. Meriwether, M.D.<br>Wewahitchka                               | J. R. Norton, M.D.<br>Port St. Joe                                 | 3rd Thursday                                                           | A-2-'41<br>B. A. Wilkinson, M.D.<br>Tallahassee        | 6       | 100% |
|                                                           | Jackson                                  | W. R. Wandek, M.D.<br>Marianna                                      | R. N. Joyner, M.D.<br>Marianna                                     | 2nd Tuesday<br>7:30 P. M.                                              |                                                        | 12      | 8    |
|                                                           | Leon-Gadsden-Liharty-Wakulla-Jefferson   | Francis T. Holland, M.D.<br>208 Midway-Moor Bldg.<br>Tallahassee    | B. A. Withkison, M.D.<br>Telephone Bldg.<br>Tallahassee            | Quarterly<br>3:00 P. M.                                                | Calhoun                                                | 39      | 21   |
| North Central District (B)<br>Lake City<br>Oct. 4, 1940   | Columbia                                 | L. J. Arnold, Jr., M.D.<br>Lake City                                | Harry S. Howell, M.D.<br>Blancha Hotel Annex<br>Lake City          | 1st Monday<br>7:30 P. M.                                               | B-3-'41<br>W. S. Nichols, M.D.<br>Lake City            | 21      | 9    |
|                                                           | Madison                                  | E. Long, M.D.<br>Madison                                            | A. F. Harrison, M.D.<br>Madison                                    |                                                                        |                                                        | 3       | 1    |
|                                                           | Taylor                                   | Geo. H. Warren, M.D.<br>Perry                                       | Ralph J. Greene, M.D.<br>Perry                                     | Last Friday<br>8:00 P. M.                                              | Baker-Dixie-Hamilton-Lafayette-Suwannee                | 7       |      |
|                                                           | Alachua                                  | Edwin H. Andrews, M.D.<br>134 N. Pleasant St.<br>Gainesville        | J. Maxey Dall, Jr., M.D.<br>333 W. Main St., S.<br>Gainesville     | 2nd Wednesday<br>7:30 P. M.                                            | B-4-'40<br>James L. Strange, M.D.<br>McIntosh          | 29      |      |
|                                                           | Marion                                   | Henry C. Dozier, M.D.<br>9 No. Magnolia St.<br>Ocala                | R. C. Cumming, M.D.<br>Commercial Bank Bldg.<br>Ocala              | 3rd Thursday<br>12:30 P. M.                                            |                                                        | 23      | 100% |
|                                                           | Pasco-Hamando-Citrus                     | Wm. H. Walters, Jr., M.D.<br>Lacoochee                              | G. R. Creekmore, M.D.<br>Brooksville                               | 2nd Thursday<br>7:00 P. M.                                             |                                                        | 15      | 8    |
|                                                           | Sumter                                   |                                                                     |                                                                    |                                                                        | Bradford-Gilchrist-Levy-Union                          | 2       |      |
| N. E. District (C)<br>Daytona Beach<br>Oct. 3, 1940       | Duval                                    | Chas. B. Mabry, M.D.<br>439 St. James Bldg.<br>Jacksonville         | Lauran M. Sompayrac, M.D.<br>459 St. James Bldg.<br>Jacksonville   | 1st Tuesday<br>8:15 P. M.                                              | C-5-'41<br>R. B. McIver, M.D.<br>Jacksonville          | 177     | 107  |
|                                                           | St. Johns                                | Donald T. Rankin, M.D.<br>East Coast Hospital<br>St. Augustine      | Vernon A. Lockwood, M.D.<br>East Coast Hospital<br>St. Augustine   | 3rd Tuesday<br>8:30 P. M.                                              | Clay-Nassau                                            | 11      |      |
|                                                           | Putnam                                   | G. M. Zeagler, M.D.<br>Glendale Hospital<br>Palatka                 | Bernard E. Kana, M.D.<br>Crescent City                             | 2nd Tuesday in<br>Feb., April, June,<br>Aug., Oct., Dec.<br>7:00 P. M. | C-6-'40<br>George M. Green, M.D.<br>Daytona Beach      | 11      | 5    |
|                                                           | Volusia                                  | L. V. L. Brown, M.D.<br>DeLand                                      | R. L. Miller, M.D.<br>238½ S. Beach St.<br>Daytona Beach           | 2nd Tuesday<br>7:30 P. M.                                              | Flagler                                                | 41      | 20   |
| Southwest District (D)<br>Dunedin<br>Oct. 31, 1940        | Hillsborough                             | John R. Boling, M.D.<br>1207 First Nat. Bk. Bldg.<br>Tampa          | James S. Grahle, M. D.<br>811 Citizens Bank Bldg.<br>Tampa         | 1st Tuesday<br>8:00 P. M.                                              | D-7-'41<br>W. C. McConnell, M.D.<br>St. Petersburg     | 109     | 51   |
|                                                           | Manatee                                  | M. M. Harrison, M.D.<br>Professional Bldg.<br>Bradenton             | W. E. Wentzel, M.D.<br>Box 245<br>Bradenton                        | 3rd Tuesday<br>7:00 P. M.                                              |                                                        | 14      |      |
|                                                           | Pinellas                                 | John A. Herring, M.D.<br>259 Third St., No.<br>St. Petersburg       | W. C. McConnell, M.D.<br>313 First Federal Bldg.<br>St. Petersburg | 1st and 3rd Fridays<br>6:30 P. M.                                      |                                                        | 104     | 102  |
|                                                           | Sarasota                                 | Millard B. White, M.D.<br>151 S. Pineapple Ave.<br>Sarasota         | Stanley T. Martin, M.D.<br>Sarasota                                | 2nd Tuesday<br>8:30 P. M.                                              |                                                        | 15      | 3    |
|                                                           | DeSoto-Hardee-Highlands-Charlotte-Glades | Hartley E. Boorom, M.D.<br>37-38 S. Ridgewood Drive<br>Sehring      | Howard V. Weems, M.D.<br>22 Oak St.<br>Sehring                     | 2nd Tuesday<br>8:00 P. M.                                              | D-8-40<br>Herman Watson, M.D.<br>Lakeland              | 20      | 11   |
|                                                           | Lee                                      | A. S. Byle, M.D.<br>311 2nd St.<br>Fort Myers                       | Fred D. Bartleson, M.D.<br>Fort Myers                              | 3rd Friday<br>7:30 P. M.                                               |                                                        | 13      |      |
|                                                           | Polk                                     | Henry Fuller, M.D.<br>Mulberry                                      | Jere W. Annis, M.D.<br>Box 1021<br>Lakeland                        | 2nd Wednesday<br>1:00 P. M.                                            | Collier-Hendry                                         | 62      |      |
|                                                           | Brevard                                  | I. M. Hay, M.D.<br>Melbourne                                        | I. K. Hicks, M.D.<br>Melbourne                                     | 3rd Tuesday                                                            | E-9-'40<br>W. C. Page, M.D.<br>Cocoa                   | 9       | 5    |
| South Central District (E)<br>Fort Pierce<br>Nov. 1, 1940 | Lake                                     | W. L. Ashton, M.D.<br>Umatilla                                      | Oliver Emerson, M.D.<br>Tavares                                    | 1st Thursday<br>12:30 P. M.                                            |                                                        | 17      | 8    |
|                                                           | Orange                                   | Chas. J. Collins, M.D.<br>209 Exchange Bldg.<br>Orlando             | Fred Mathers, M.D.<br>Box 53<br>Orlando                            | 3rd Wednesday<br>8:30 P. M.                                            |                                                        | 81      | 61   |
|                                                           | Seminole                                 | Wade H. Garner, M.D.<br>Sanford                                     | Douglas G. Scott, M.D.<br>212 N. Park Ave.<br>Sanford              | 2nd Monday<br>7:00 P. M.                                               | Osceola                                                | 12      |      |
|                                                           | St. Lucie-Okeechobee Indian River-Martin | Francis A. Gowdy, M.D.<br>Ft. Pierce                                | Adrian M. Sample, M.D.<br>Ft. Pierce                               | 3rd Thursday<br>8:00 P. M.                                             | E-10-'41<br>A. M. Sample, M.D.<br>Ft. Pierce           | 17      | 14   |
|                                                           | Broward                                  | L. B. Elliston, M.D.<br>814 Sweet Bldg.<br>Ft. Lauderdale           | E. C. Chamberlain, M.D.<br>720 Sweet Bldg.<br>Fort Lauderdale      | 4th Wednesday<br>8:00 P. M.                                            | F-11-'40<br>Lloyd J. Netto, M.D.<br>West Palm Beach    | 36      | 2    |
| S. E. District (F)<br>Key West<br>Nov. 2, 1940            | Palm Beach                               | James H. Pittman, M.D.<br>Box 602<br>W. Palm Beach                  | C. Jennings Derrick, M.D.<br>Box 574<br>W. Palm Beach              | 4th Monday<br>8:00 P. M.                                               |                                                        | 62      |      |
|                                                           | Dade                                     | Joseph S. Stewart, M.D.<br>525 duPont Bldg.<br>Miami                | Franz Stewart, M.D.<br>525 duPont Bldg.<br>Miami                   | 1st Tuesday<br>8:30 P. M.                                              | F-12-'41<br>Kenneth Phillips, M.D.<br>Miami            | 293     |      |
|                                                           | Monroe                                   | Harry C. Galey, M.D.<br>532 Fleming St.<br>Key West                 | W. R. Warren, M.D.<br>511 Eaton St.<br>Key West                    | 1st Sunday<br>9:00 P. M.                                               |                                                        | 5       | 100% |



STATE AND SECTIONAL MEETINGS

| SOCIETY                         | PRESIDENT                         | SECRETARY                           | ANNUAL MEETING                   |
|---------------------------------|-----------------------------------|-------------------------------------|----------------------------------|
| da Medical Association.....     | Leigh F. Robinson, Ft. Lauderdale | Shaler Richardson, Jacksonville.... | Tampa, Apr. 29, 30 & May 1, 1940 |
| da Medical Districts:           |                                   |                                     |                                  |
| -Northwest .....                | B. A. Wilkinson, Tallahassee..... | Stewart Thompson, Jacksonville....  | Pensacola, Oct. 5, 1940          |
| -North Central .....            | William S. Nichols, Lake City.... | " " "                               | Lake City, Oct. 4, 1940          |
| -Northeast .....                | Robt. B. McIver, Jacksonville.... | " " "                               | Daytona Beach, Oct. 3, 1940      |
| -Southwest .....                | W. C. McConnell, St. Petersburg.  | " " "                               | Dunedin, Oct. 31, 1940           |
| -South Central .....            | A. M. Sample, Ft. Pierce.....     | " " "                               | Ft. Pierce, Nov. 1, 1940         |
| -Southeast .....                | Kenneth Phillips, Miami.....      | " " "                               | Key West, Nov. 2, 1940           |
| ama Medical Association.....    | M. S. Davie, Dothan.....          | D. L. Cannon, Montgomery.....       | Birmingham, April 16-18, 1940    |
| gia, Medical Assn. of.....      | W. H. Myers, Savannah.....        | E. D. Shanks, Atlanta.....          | Savannah, April 23-26, 1940      |
| da—                             |                                   |                                     |                                  |
| ate Dental Association.....     | E. B. Penn, Miami.....            | E. C. Lunsford, Miami.....          | St. Petersburg, Nov., 1940       |
| c. of Derm. and Syph.....       | Alan Brown, Jacksonville.....     | Lauren M. Sompayrac, Jacksonville   | Tampa, April 29, 1940            |
| st Coast Medical Association..  | I. M. Hay, Melbourne.....         | J. S. Stewart, Miami.....           | Miami, 1940                      |
| ate Hospital Association.....   | J. H. Therrell, Chattahoochee.... | Mr. Fred M. Walker, Jacksonville..  | Mississippi, March, 1940         |
| sn. of Industrial Surgeons..... | Harrison A. Walker, Miami Beach   | A. M. Bidwell, Tampa.....           | Tampa, Apr. 29, 1940             |
| ernists' Society.....           | W. C. Blake, Tampa.....           | Kenneth Phillips, Miami.....        | Tampa, Apr. 29, 1940             |
| edical Postgraduate Course...   | Turner Z. Cason, Jacksonville.... | Chairman                            | Jacksonville, June 24-29, 1940   |
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| tahoochee Valley Med. Assn...   | M. Y. Dabney, Birmingham.....     | Frank K. Boland, Atlanta.....       | Albany, Ga., July 9-11, 1940     |
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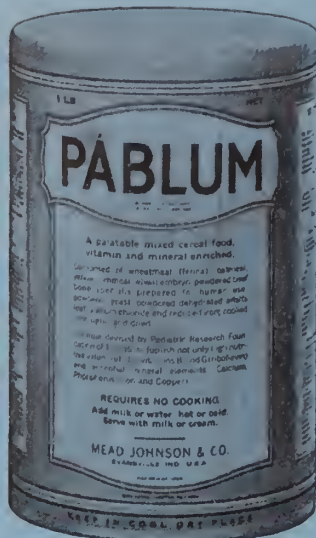
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## *STUDIES IN THE AVITAMINOSES*

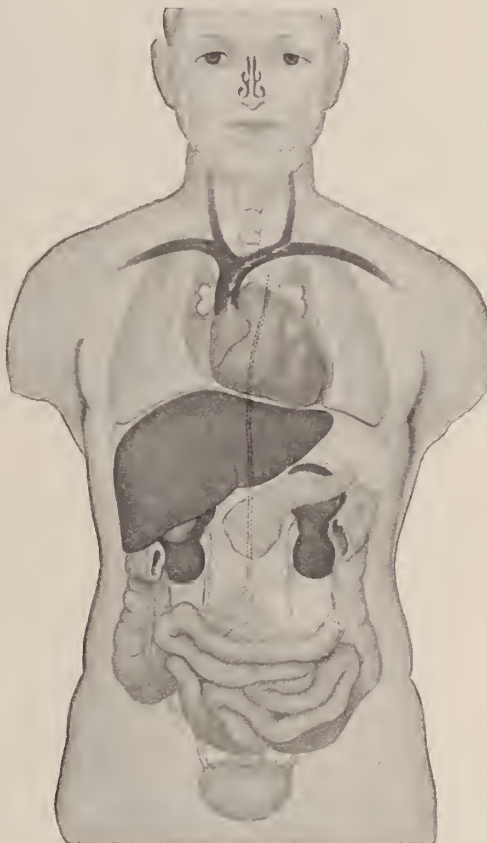


This page is the fourth of a series on vitamin deficiencies presented by the research division of The Upjohn Company because of the profession's widespread interest in the subject. A full color, two-page insert on the same subject appears in the April 6 issue of The Journal of the American Medical Association.

### **Metabolic Fate of Vitamin A and Carotene**

Vitamin A and carotene are absorbed into the lacteals with the fat of the food ingested. It is generally agreed that vitamin A in large quantities is more speedily absorbed than are similar quantities of carotene.

The fat-soluble vitamins enter the general circulation by way of the thoracic duct. In the liver, vitamin A and carotene are taken up by the Kupffer cells, where carotene is slowly converted to vitamin A. Experimental studies indicate that vitamin A is stored in the liver in certain species, including man.



### **The Causes of Vitamin A Deficiency**

Vitamin A deficiency may be caused by inadequate intake of the vitamin or provitamin. Absorption may be retarded, depending on the condition of the alimentary tract. For example, mineral oil in the intestine diminishes absorption of carotene although not of vitamin A. Conversion of carotene to vitamin A in the liver may not occur, as in diabetes mellitus, where evidence indicates that the rate of transformation of carotene is diminished, and vitamin A deficiency may develop even if the diet provides the provitamin in amounts ordinarily sufficient.

### **Effects of Vitamin A Deficiency**

Vitamin A deficiency produces pathologic changes in many organs. The process is one of alteration of epithelial surfaces — keratinizing metaplasia of the epithelium of the urinary bladder, the ureters, the ducts of the salivary glands and the pancreas, the trachea, and the nose. In the eye, vitamin A deficiency interferes with restoration of visual purple, resulting in night blindness. Prolonged vitamin A deficiency produces xerophthalmia. Administration of adequate quantities of vitamin A to patients manifesting symptoms of deficiency usually checks the progress of epithelial alteration.



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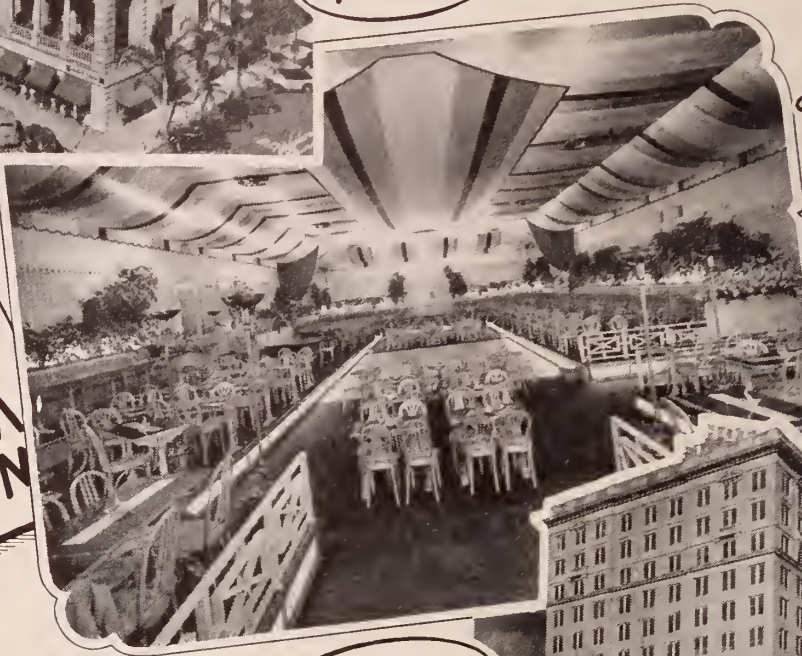
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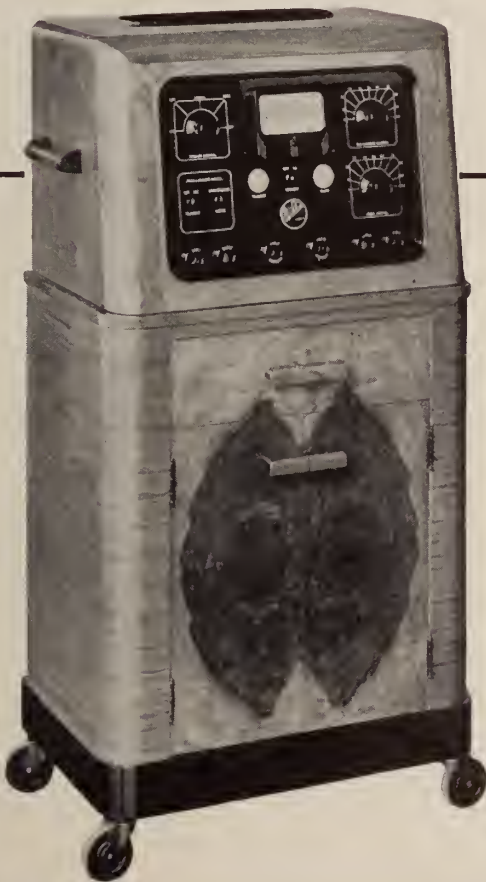


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## ATROPHIC RHINITIS AND OTOSCLEROSIS

TREATMENT WITH ESTRIN ALONE AND  
COMBINED WITH OTHER THERAPY

S. B. FORBES, M. D.,  
Tampa

Atrophic rhinitis is familiar to all of us. As defined in Lederer's new text,<sup>1</sup> it is an atrophic condition of the nasal mucous membrane, often also of the underlying bony structure, characterized by the formation of crusts, abnormal patency of the nasal chambers and frequently by pronounced ozena laryngis or fetor.

Mortimer, Wright and Collip<sup>2</sup> reported a definite relationship between pituitary dysfunction and atrophic rhinitis. Blaisdell,<sup>3</sup> on the other hand, examined roentgenologically a series of more than 70 cases for evidence of pituitary dysfunction, but in none of the skulls was any pituitary abnormality observed. These investigators agreed, however, that estrin, the female sex hormone, produces changes of an order opposed to those occurring in atrophic rhinitis. The established fact that such changes occur normally, cyclically, in the monkey and in the nose of the human female in pregnancy justified and encouraged the use of this substance locally in the treatment of this disease in man, on the ground that the nasal mucosa responds specifically to estrogenic stimulation. On the basis of experimental work on the monkey, Mortimer and his associates<sup>2</sup> concluded that it is reasonable to suppose that this treatment induces a hyperemia, an increased glandular activity in the mucosa, and, perhaps, in time, an actual increase or hyperplasia of the mucosal glands.

Estrin is obtained from the follicular liquid of man and other mammals, and its formation is cyclical rather than constant or uniform. Zondek<sup>3</sup> concluded that the production of estrin never ceases entirely, but falls to a minimum after menstruation and reaches its maximum in the pre-pregnant

stage. Massive production of this follicular hormone sets in acutely with pregnancy as soon as the fertilized ovum has come in contact with the maternal circulation. In many patients with atrophic rhinitis the nasal condition improves temporarily during the period of pregnancy. The increased secretion is nevertheless not dependent upon pregnancy, since this hormonal increase occurs only in a few mammals, including man and the monkey.<sup>3</sup>

As is well known, atrophic rhinitis usually begins about the age of puberty, and the condition seems to improve spontaneously when the patient reaches the age of 45 or 50 years. This remission coincides with the increased production and excretion of estrin associated with the climacteric. Younger women are advised to watch for an increase in the menstrual flow and tenderness of the breasts while under treatment with this substance.

Although prolonged administration of estrin to male experimental animals resulted in pathologic changes, these effects are not regarded as contraindicating its use in the treatment of male patients with atrophic rhinitis. Hamilton<sup>3</sup> concluded, however, after observing changes in the nasal mucosa of both monkeys and humans following the use of testosterone propionate, that treatment with the male hormone comparable to estrin is contraindicated in females since it exerts a direct masculinizing effect. Both sex hormones are present in every body, and each apparently has a definite effect on the nasal mucosa. According to Zondek's theory, the female hormone present in the male body is a decomposition product of the male hormone, and, conversely, the male hormone in the female body is a preliminary stage in the natural synthesis of the female hormone.<sup>3</sup> Estrin is found in the greatest amounts in the urine of male animals.

Especially since it was established that some of the carcinogenic hydrocarbons are estrogenic, experimentation has been stimulated by the chemical similarity of estrin and the carcinogenic hydrocarbons. Investigators

Read before the Sixty-sixth Annual Meeting of the Florida Medical Association, held at Daytona Beach, May 1, 2 and 3, 1939.

have reported the formation of sarcomas, carcinomas and benign epithelial proliferations in various organs of experimental animals treated over long periods with estrin and its allied chemical substances. Cramer<sup>3</sup> observed that the action of estrin is similar to that of other carcinogenic agents in that it produces the hyperplasia of the tissues characteristic of the precancerous condition, but he concluded that a specific physiologic sensitiveness to the carcinogenic agent is responsible rather than the carcinogenic agent itself, as with other carcinogenic substances so far studied experimentally. There is, then, the possibility that the use of estrin in the treatment of the nasal mucosa may induce cancer in the patients so treated, but the consensus is that this contingency is extremely unlikely in these cases with the small dosages thus far used.

The cases here summarized are divided into three groups according to the type of treatment used. Group 1 used estrin in the form of amniotin in oil as a nasal spray three times a day, and an occasional irrigation of the nose was done at home or in my office to remove crusts so that the spray could better contact the tissues. In the treatment of group 2, the nasal spray was supplemented by nasal packs of the amniotin concentrate and by injections of 2,000 units of theelin in oil at intervals of from five to

seven days. Treatment of group 3 included, in addition to the foregoing procedures, the implantation of ivory into the septum on either side in order to reduce the breathing spaces.

#### CASE REPORTS

Group 1 consisted of three cases. The first patient, a physician, aged 46 years, who had been intermittently under my care for four years, had a pronounced argyria nasalis with a definite atrophic rhinitis. The fetor and the large crusts disappeared within one week after he began using the spray. Occasionally now small flakes come down posteriorly, but there is a distinct improvement in the color of the whole nasal mucosa. The second patient, a woman, aged 70 years, had decided symptoms, but is now perfectly comfortable using the spray one week out of every month. The third patient, a woman, aged 45 years, was referred to me by Dr. William MacDougall of Atlanta. She stated that she had had atrophic rhinitis for several years and had used various older forms of therapy, singularly enough, having had the most relief from Sulzberger iodine powder. After treatment, she left the city and later, when I began using the new therapy, she was instructed by mail to use the spray. Three months afterward, she reported that the crusts had entirely disappeared, and her husband informed me confidentially that the fetor had ceased to be noticeable after the first week of this treatment. Clinical examination of the nose showed no crusts of any consequence and a rather pink mucosa despite a considerable degree of atrophy and an extremely roomy nose.

In group 2, four cases were treated. The first patient of this group, a physician's daughter, aged 29 years, living in Trinidad, presented a typical case with crusting particularly in the nasopharynx. A diagnosis



FIGURE 1

Figure 1.—Roentgenograms show the surgical narrowing of the breathing spaces by the implantation of ivory into the septum.



of posterior sinusitis had been erroneously made and autogenous vaccine given. For hypothyroidism she had been given  $\frac{1}{2}$  grain of thyroid extract twice a day and had also had injections of theelin prior to consulting me. In addition, she had been subject to frequent attacks of eustachian salpingitis. Combined with injections of theelin at intervals of five days and nasal packs of the amniotin concentrate, the amniotin spray relieved her within ten days. Under like treatment the second patient, a woman, aged 43 years, in the climacteric, improved greatly within a month, and her general health was benefited.

The third patient, a man, aged 42 years, improved only slightly under treatment with the nasal spray and packs, but two injections of theelin entirely changed the nasal picture. He was given four more injections and now uses the spray three times a week. The fourth patient, a woman, aged 38 years, greatly depressed mentally, was referred to me by Dr. D. D. Martin. Because of pronounced nasal symptoms she had been under treatment in Cincinnati for several weeks. Examination showed that most of the discharge was from the left side anteriorly, and the fetor was fairly noticeable. A crust covering practically the entire lateral wall in the ethmoid region, one of the largest I ever saw, was removed. In the nasal culture there was a predominance of *Streptococcus viridans*, nonhemolytic streptococci and *Staphylococcus aureus*. After the patient was treated for ten days with the spray and packs and the injections of theelin, the crusts disappeared entirely. She is now comfortable using the spray daily and is no longer depressed.

The one case in group 3 was that of a young woman, aged 16 years, who had first consulted me in 1933 because of a severe case of atrophic rhinitis. The usual treatment was prescribed at that time. When she returned in July, 1938, with the condition much worse, implantation of ivory into the septum was done. Roentgenograms of the implant are shown in figure 1. Although the septum was impacted against the inferior turbinate on the left side, there was no great improvement in the nasal condition. In October, 1938, the use of amniotin as a nasal spray was prescribed, and the condition was soon somewhat improved though still far from satisfactory. Injections of theelin at weekly intervals were started in January, 1939, and great improvement resulted. The patient's father reported that after several injections the fetor disappeared. In this case, even after surgically narrowing the breathing spaces and using the nasal spray and packs, it was necessary to supplement this treatment with injections of estrin. Dr. R. Percy Wright,<sup>4</sup> one of the group of investigators at McGill University who developed the treatment of atrophic rhinitis with the estrogenic substance, regarded this type of combined surgical and estrogenic therapy, when warranted, as decidedly the treatment of choice. Pollock<sup>5</sup> stressed the value of the surgical procedure.

None of my cases in this short series was complicated by disease of the sinuses. Had sinusitis been present, I should have attended first to this condition. In cases of disease of the ethmoids, irradiation is certainly to be preferred, as Wright<sup>4</sup> observed, to intranasal surgery that removes the much needed nasal wall.

In their series of 68 cases of atrophic rhinitis, Mortimer and his associates<sup>2</sup> found 7 patients suffering also from progressive deafness, and in an eighth patient both otosclerosis and hypertrophic rhinitis were present. From their observation of this group

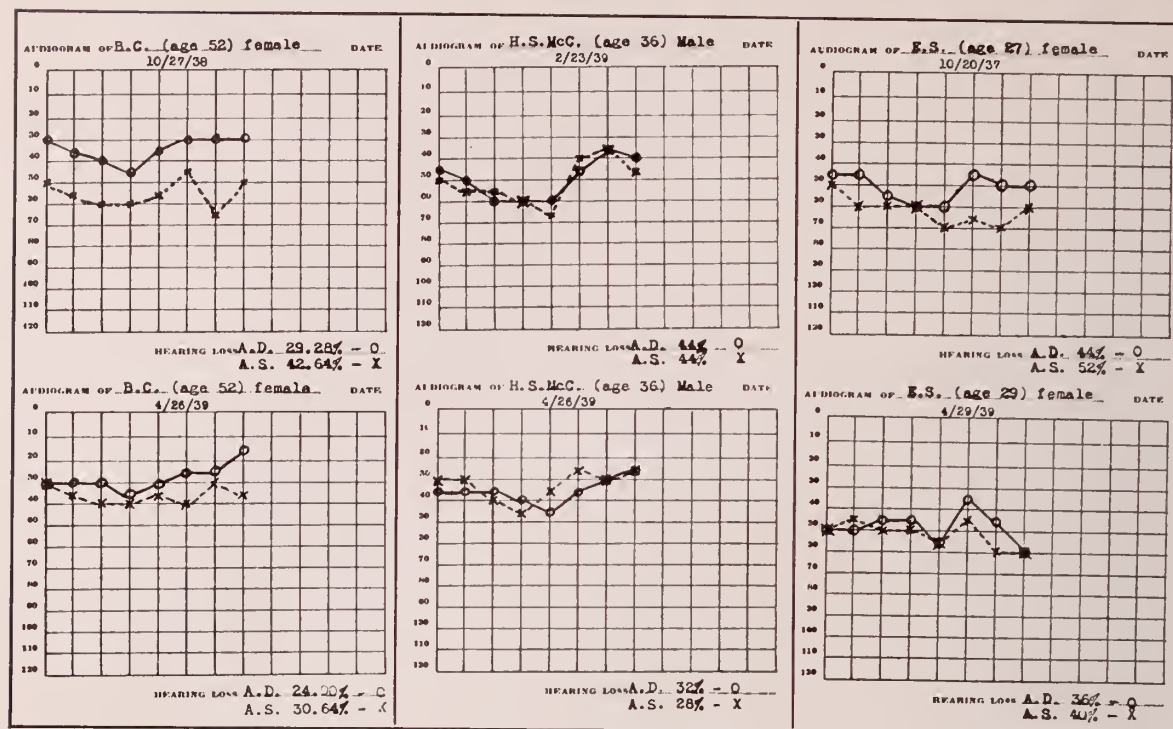
and the study of 70 cases of progressive deafness, they found roentgenologic evidence that in both diseases there is the same constitutional background and they came to suspect an otogenital relationship since treatment in certain cases gave encouraging results, particularly in regard to tinnitus.

Stimulated by Wright's suggestion of estrogenic treatment in otosclerosis, I determined to combine this therapy with intratympanic injections of thyroxin as described by Goldstein,<sup>6</sup> using the technic of Gray.<sup>7, 6</sup> Since the history of otosclerosis is one of definite loss of hearing, as a rule, with each pregnancy, estrin would seem to be contraindicated. My observations up to the present time, although very limited, seem to indicate the beneficial effect at least of the combined treatment. This treatment consists of injections of 2,000 units of theelin in oil at weekly intervals, combined with the nasal spray of amniotin in oil and intranasal packs of the amniotin concentrate, and injections of 1/64 grain of thyroxinesodii, given weekly, one ear at a sitting. Eight injections are made in all, four in each ear. The needle used for the injection of the thyroxin in the nine cases treated in my series was described by Goldstein,<sup>6</sup> and the only variation in Gray's technic was the insertion of a eustachian bougie into the tube during and for several minutes after the injection to prevent the escape of the solution through the tube. No complications were observed in my cases although a few of the patients experienced vertigo and some pain on the night following the injection.

The clinical diagnosis of otosclerosis in the cases selected was based on the familial history of progressive deafness, audiometric and tuning fork tests, defects in the upper and lower tone range, negative Rinne's tests, patent eustachian tubes, normal membrana tympani, the presence of tinnitus and paracusis willisiana with progressive loss of hearing in both ears. Seven of the nine patients were women and two were men. Their ages ranged from 13 to 52 years. Audiograms of the results are shown in figure 2.

To improve the hearing in cases of otosclerosis, this method of treatment is worthy of trial and is to be preferred at present to

FIGURE 2



the more radical therapeutic measure recently described by Lempert.<sup>8</sup> His delicate, technical surgical procedure is designed to create a new fistula in the external semicircular canal that will remain permanently open, permitting sound waves to enter the labyrinth by this abnormal route. Crowe<sup>9</sup> observed: "It would

be an ideal method for improving the hearing and avoiding use of mechanical hearing aids in patients whose inner ear and nerve are normal, provided the fistula remained open. New bone forms, the fistula closes and the hearing impairment gradually returns to the preoperative level—at least this has been

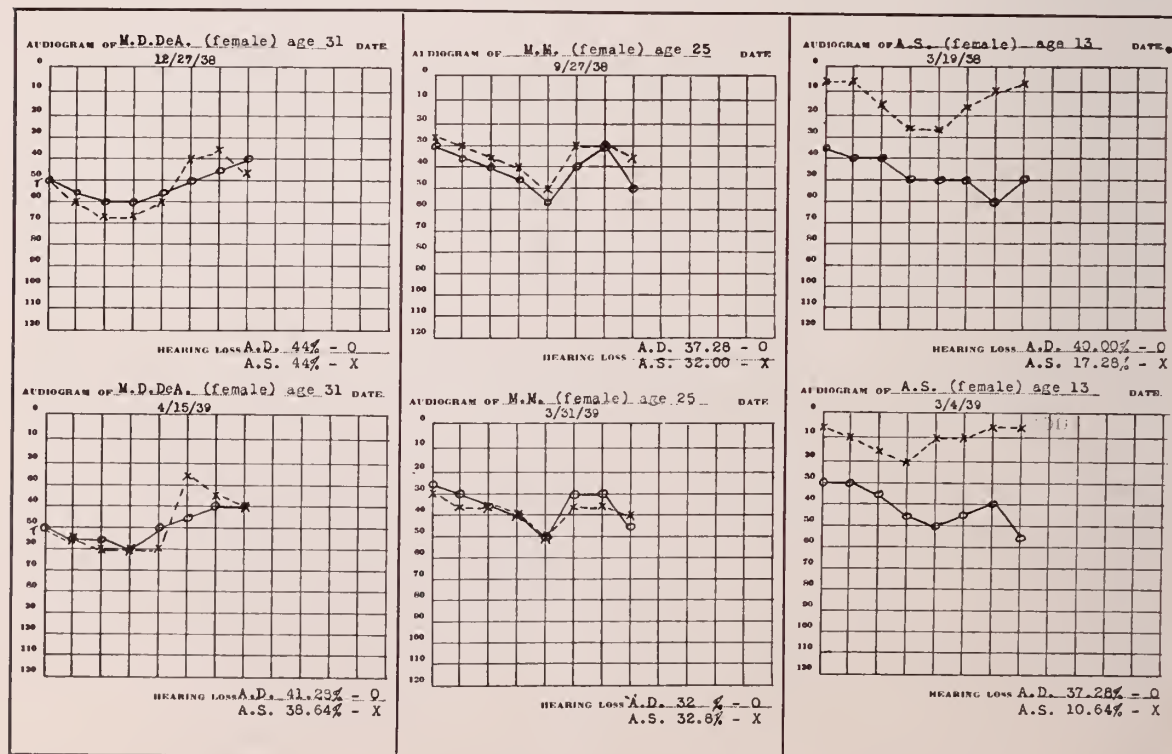


Figure 2.—Audiograms chart the improvement of hearing of patients with otosclerosis as the result of treatment with estrin and intratympanic injections of thyroxin.



the experience of others doing this type of operation. Many operations of this kind have been done on monkeys, and histologic studies have invariably shown the fistula closed after a few months."

Estrin, aside from its function as a sex hormone, acts as a drug whose action has been described as "more far-reaching than insulin, more powerful than adrenalin, and more spectacular than ergot." It gives promise of attaining an important place in the armamentarium of the otolaryngologist, but a correct evaluation of its exact therapeutic role will come only with time as the study of this estrogenic substance progresses.

#### SUMMARY

In my small series of cases, the use of estrin in the treatment of 8 cases of atrophic rhinitis resulted in the clinical improvement of symptoms in all patients.

As long as the estrin was used, the patients remained almost entirely free of symptoms.

In some cases it was necessary to supplement the local nasal treatment with injections of estrin, even when the nasal breathing space had been surgically narrowed.

The permanency of the clinical improvement resulting from this therapy will be established only after years of careful study of treated cases.

In the nine cases of otosclerosis included in this series, the hearing of two-thirds of the patients was improved under treatment with estrin combined with intratympanic injections of thyroxin. In all but one case tinnitus decreased appreciably.

The permanency of the improved hearing will not be known until further study is made of treated cases.

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#### DISCUSSION

*Dr. H. Marshall Taylor, Jacksonville:*

Some savant has said that one of the requirements of a good paper on a medical subject is that it has the quality of making one think. This paper which Doctor Forbes has presented certainly gives one a great deal of food for thought.

He has written of two conditions which, until within the last few years, were hopeless so far as a favorable prognosis was concerned. In one of these conditions, Doctor Forbes reports 100 per cent recovery; in the other he reports 66⅔ per cent recovery. It is to be hoped that Doctor Forbes will go on with this work and if he can accomplish similar results in his future cases, he has done something which is not short of being dramatic.

The results of the treatment of atrophic rhinitis throughout the years have been most unsatisfactory to both the patient and the physician. Many things have been offered for its relief. At one time many rhinologists were very enthusiastic about the results obtained from the topical application of scarlet red. In recent years this treatment has been thrown into the discard. The surgical measures as carried out by Pollack for a time had many advocates. Today this treatment has been discarded. It now seems that the use of estrogenic substances promises more in giving relief to those suffering from atrophic rhinitis than any treatment previously advocated. I now have three patients on this treatment which up to the present time have shown a marked amelioration, crusting having disappeared, odor greatly diminished, and the mucous membrane beginning to take on a more healthy color.

The two conditions which Doctor Forbes has written of in his paper—atrophic rhinitis and otosclerosis—are probably due to a diminished blood supply. Dr. Albert Gray of Middlesex Hospital, London, when cocaine first came into use, in his studies to lessen the toxicity, of the drug, conceived the idea of making topical applications of thyroxin, a hormone of the thyroid gland, to the nasal mucous membrane, for he observed that it caused an active congestion of the blood vessels of the part. Later, Doctor Gray, accepting the theory that otosclerosis was due to a diminished blood supply, injected thyroxin through the ear drum into the middle ear for the purpose of causing an active hyperemia of the mucous membrane of the tympanum. Doctor Gray made very favorable reports of the success of his method in the treatment of otosclerosis, but, unfortunately, his closest contemporaries after using the same method could not claim the favorable results which Doctor Gray obtained.

In this country the thyroxin treatment for otosclerosis has met with little enthusiasm. Babbitt, in summing up his report of his results after using the thyroxin treatment in seventeen cases, concluded by saying: "Hearing was generally not impaired, though but slightly improved." He reports that two of his patients, after

injection of thyroxin, showed an otitis media, and ends with the statement: "The composite conclusion from all sources would rather appear to me as unfavorable as to relief of deafness but at least partially successful in diminishing tinnitus."

After reading Doctor Forbes' paper, I cannot but wonder whether the improvement in hearing which he reports is not due to his estrogenic treatment, rather than to the use of thyroxin. So far as I know, no one previously has combined the two treatments. Doctor Forbes should be congratulated on his results, for I do not believe that any other American otologist has approached the success which he has reported in the treatment of otosclerosis. Doctor Forbes owes it to Medicine to continue his research along this line, and I hope that at a later date he will present another thesis on this subject, and that his future results will compare favorably with the cases he has reported in this paper.

*Dr. Gail E. Chandler, Miami:*

On receiving Doctor Forbes' paper and reading it, I immediately telephoned a number of nose and throat men here in Miami (all I could reach at that time), and asked how many cases of ozena or atrophic rhinitis they had seen. I was told they had not seen any cases originating in Miami and not more than one or two which had been referred to them from other parts of the United States.

For myself, in the fourteen years I have been practicing in Miami I have not had a single case of this kind to come under my care and am of course not following this line of work.

The fact that Doctor Forbes has found the use of estrin and thyroxin helpful in these cases is certainly interesting and we hope he will continue with his work. If we can retard the progress of otosclerosis, even if we cannot cure it, we will have made marvelous progress, certainly in the early cases.

*Dr. M. A. Lischkoff, Pensacola:*

Two years ago I spent a short time with Wright in order to obtain first-hand information on this subject. The results in some of his cases of ozena were very worthwhile, skeptical as one might be.

The relationship between pituitary dysfunction and atrophic rhinitis led to the investigation of the nasogenital relation in the monkey and the recognition of the fact that estrogenic substances produce a specific response in the nasal mucosa closely akin to that resulting in other sexskin areas. There being a physiological similarity in the nasal and vaginal mucosa and because of pathological similarity in atrophic rhinitis, and atrophic vaginitis, estrogenic substance has been used in the nose.

My own observations are limited to a very few cases all within a period of six to eighteen months, but do not bear out Doctor Forbes' enthusiasm. In the case of one female who improved rapidly, her audiogram showed a conversational loss of approximately 18 per cent in August, 1938, and after estrogen in oil spray twice daily, plus theelin injections and other treatment, her conversational loss was reduced to 10 per cent. An unmarried woman of thirty with simple atrophic rhinitis began using estrogen hormone and oil spray in February, 1938, and at present her nasal mucosa is not as pale and she is generally improved. Her hearing loss is less now as shown in her audiogram. A young, otherwise husky male, with ozena improved temporarily after topical applications of estrogen substance, and a hormone spray, but after six weeks had retrogressed. He did not continue treatment and disappeared from observation.

I don't agree with Doctor Forbes as to intratympanic injections of thyroxin. I have used it ever since Gray brought it out, and have come to the conclusion that it is of no value in tinnitus. In none of my cases was there any definite improvement in hearing.

His ingenious blocking of the eustachian tube with a bougie is certainly original, but is not physiologically correct, because of the possibility of producing a lesion from the obstruction.

As all pioneers in new work, Dr. Forbes will be disagreed with, but I am very much interested in this, and believe all otorhinologists should feel that way. For it and a most interesting paper, I congratulate him.

*Dr. S. B. Forbes (Concluding):*

I want to thank Doctor Taylor for his very illuminating discussion. I want to remind the doctor that I did not mention a cure in either of these conditions. We are dealing with two diseases heretofore considered absolutely hopeless and if we can offer the slightest relief, I think that the treatment is justified. As mentioned, this is only a very preliminary report and I hope later to be able to answer some of Doctor Taylor's questions.

Doctor Lischkoff mentions a case of otosclerosis in which he used injections of thyroxin without results. We combine the thyroxin with estrogenic therapy, injections, nasal tampons, spray, etc., and we feel that we have had some definite improvement.

As I said, this is all just in a very formative stage and I hope that this little discussion is a stimulus for further study.

## HEMORRHAGE COMPLICATING EMPYEMA THORACIS

WITH REPORT OF A FATAL CASE

SIDNEY G. KENNEDY, M. D., and

J. H. PIERPONT, M. D.

Pensacola

Hemorrhage constitutes one of the true emergencies of the practice of medicine and is both appalling and unnerving to doctor and patient alike. After experiencing in our own practice a case of empyema of the chest which terminated fatally because of profuse hemorrhage, it was our desire to learn more about this serious complication which may occasionally occur in these cases. It is therefore the purpose of this paper to attempt an outline of the pathological conditions, mainly from an anatomical viewpoint, which may operate to bring about this condition, and to present our own case. Treatment, though all important, will be treated in a cursory manner, specific measures for the control of hemorrhage at its source being mentioned in the general discussion. Supportive measures such as absolute quiet and rest, relief from pain, transfusions, fluids administered intravenously and subcutaneously, will not be discussed in detail.

In reviewing the literature on empyema, one is amazed at the scarcity of material available

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on this subject, but this is more fully appreciated when it is found that statistics reveal probably less than one per cent of empyema deaths resulting from hemorrhage. Many cases have undoubtedly gone unrecorded. In a study of one hundred consecutive deaths due to empyema from the records of Charity Hospital in New Orleans, Maes, et al.<sup>1</sup> reported only one case due to hemorrhage, that of rupture of an aneurysm following a particularly violent coughing spell. Other series of cases<sup>2, 3, 4</sup> have been reported in which hemorrhage was not listed as a cause of death.

Hemorrhage, though complicating, may not in a strict sense be a true complication of the empyema, but rather a complication of the condition preceding and originating it. For instance, hemorrhage coming from destruction of a blood vessel in an abscess of the lung, which abscess had previously ruptured into the pleural cavity producing empyema, cannot be considered as brought about by the empyema but rather as originating from the abscess. However, to make such a pathological distinction clinically is often impossible; in fact, diagnosis of the origin of hemorrhage, so that a plan of procedure may be outlined, is usually most baffling. T. Oliver<sup>5</sup> in 1906 reported three cases of fatal hemorrhage following incision of the chest wall for drainage of empyema in which autopsy failed to reveal the origin of the hemorrhage.

The following outline of the possible anatomical sites and causes of hemorrhage may be of some value in arriving at a diagnosis:

- I. Blood vessels of the chest wall.
  - a. Operative trauma—failure of ligature, damage to a vessel overlooked at operation, postoperative oozing.
  - b. Pressure from drainage tube.
  - c. Infection — direct extension to vessel from tissues or from osteomyelitis of a rib.
- II. Pleural granulations and damage to lung tissue.
- III. Pulmonary vessels.
  - a. Anomolies.
  - b. Pulmonary abscess.
  - c. Pulmonary gangrene.
- IV. Aneurysm.
- V. Subclavian vessels.
- VI. Hemorrhagic diseases—purpuras, leukemias and hemophilia.

Other points of origin which have been mentioned include: the aorta, venae azygos, and the venae cavae.<sup>6</sup>

The problem of hemorrhage from the chest wall is, generally speaking, identical with that of any infected wound. It may be immediate or delayed and may occur from the blood sup-

ply of muscles or from an intercostal vessel.<sup>6</sup> Failure of ligature, damage to a vessel which has been overlooked at operation, postoperative oozing, pressure from the drainage tube,<sup>7</sup> and infection either direct or from an osteomyelitis of a rib,<sup>8</sup> are some of the causes which may operate to bring it about. Not infrequently we see a small hemorrhage from this source which calls for no special treatment other than removal of the tube and complete rest, but a large hemorrhage may call for exploration of the operative wound with the use of suture, ligature or packing. Packing<sup>9</sup> is particularly useful with postoperative oozing or bleeding from granulation tissue. By virtue of its location, hemorrhage from the chest wall offers the most favorable prognosis.

The formation of excessive granulation tissue on the pleurae occurs at times and occasionally this is a source of considerable hemorrhage. A. Jacobi<sup>8</sup> in 1901 reported a case of a seven year old girl with empyema of the right chest who at operation (rib resection) lost about 250 cc. of blood from an area of large granulations located on the pulmonary pleura which could be visualized through the incision. Hemorrhage was controlled by packing the cavity on three successive occasions and recovery was uneventful though somewhat retarded. There was no suspicion of malignancy or tuberculosis. The drainage tube can come into contact with pleural granulations causing hemorrhage, hence again removal of the tube along with conservative and supportive treatment may suffice for control. Damage to pulmonary tissue either by injury at operation, by pressure of the tube, or by extension of the infective process into the lung may also be the cause of hemorrhage.

The presence of coincident abscess or gangrene<sup>11</sup> of the lung may bring about exposure of a branch of a pulmonary vessel<sup>6</sup> with subsequent infection and breaking down of the vessel wall with resulting hemorrhage which is frequently initiated by a particularly violent spell of coughing, and which may be evidenced only by hemoptysis and shock, depending upon whether there is communication with the pleural cavity. Very rarely an anomalous pulmonary vessel may rupture into the pleural cavity. Such a case, which did not have empyema, was reported by H. Gillet<sup>10</sup> in 1888 in which a pulmonary vein terminating abnor-

mally into somewhat of a cul-de-sac had ruptured into the right pleural cavity with a fatal termination within six weeks. Needless to say, hemorrhage from such sources, even if diagnosed, is almost impossible to control. Beyer<sup>12</sup> reported two cases of ligation of a branch of the pulmonary artery with control of hemorrhage where other measures had failed. He pointed out that this method will be of no avail if bleeding is from the bronchial artery.

A case of rupture of an aneurysm as cause of fatal hemorrhage in empyema as reported by Maes has already been mentioned. Other cases have occurred.<sup>5</sup>

Hemorrhagic diseases complicating empyema thoracis must be exceedingly rare but certainly can occur. Among them are the purpuras, the leukemias and hemophilia. Laboratory procedures as precautionary measures are: the bleeding and coagulation time, the capillary resistance test and a study of the clot.<sup>13</sup> A careful family history, together with a past history of abnormal bleeding following cuts and minor injuries, should be taken.

We were able to locate only one reported case of hemorrhage originating from a subclavian vessel, that of G. H. Edington<sup>14</sup> reported in 1907. Because of its similarity to the one reported below it is herein reported briefly.

The case is that of a female infant aged 10 months who had a partial resection of the eighth rib posterior axillary line for an empyema of the left pleural cavity. Hemorrhage occurred through the drainage tube on the fifteenth postoperative day. The tube was removed and packing was placed in the wound and removed two days later at the same time a smaller tube was inserted. Fatal hemorrhage occurred on the twenty-third postoperative day. Post-mortem findings were: "... a probe introduced into the wound in the chest wall passed upwards and was visible at one part where the lung, on removal, tore a rent in the smooth, thick fibrinous layer which corresponded in surface appearance and situation to the costal pleura. On enlarging this rent the track of the tube was exposed, containing blood clot, and having its walls blood-stained. A finger could be passed up behind the subclavian vein. On dissecting the vein upwards and forwards, the tissues behind it were seen to be blood-stained. The upper limit of the tube track was formed by the subclavian artery. In the under part of the vessel there was a clean cut opening in the wall. . . . On introducing the original drainage tube into the track, it was found that the pointed end of the tube fitted into the aperture in the vessel wall."

The lesson to be learned from this case, and which the author points out, is that of guarding against excessive length of the drainage tube.

#### CASE REPORT

P. S., a white male, aged 8 years, became ill on May 9, 1938, with pain along the lower left costal margin which was increased on inspiration without cough. Tem-

perature range was 99 F. to 102 F., pulse 100, and respiration 28.

Physical examination at this time was essentially negative except for diminished breath sounds over the lower half of the left chest anteriorly and posteriorly and increased dullness to percussion; there was also slight tenderness and spasticity of muscles of the left upper abdomen. Leukocyte count was 18,000, with polymorphonuclears 88 per cent and small lymphocytes 12 per cent. On May 11, x-ray examination of the chest revealed increased density over the entire left chest which was diagnosed as a probable pneumonia. The patient's condition remained unchanged and on May 12 the leukocyte count was 20,000 with 90 per cent polymorphonuclears and with temperature ranging from 100 F. to 104 F. There was a moderate nonproductive cough.

On May 16 the x-ray revealed what appeared to be a left pleural effusion and, in view of the blood count and temperature, it was thought he probably had an empyema. Attempt at aspiration 6th intercostal space mid-axillary line at this time was unsuccessful, although there was flatness on percussion of the entire left chest posteriorly and laterally with absence of breath sounds. The leukocyte count had not increased. The red cell count was 3,810,000 with 70 per cent hemoglobin (Sahli). On May 20 the leukocyte count had increased to 28,000 with 92 per cent polymorphonuclears.

From an x-ray examination May 24 a diagnosis was made of left empyema and the patient was taken to the operating room preparatory to aspiration and rib resection. Shortly before this could be carried out he experienced a violent coughing spell and brought up large quantities of foul smelling pus. Aspiration revealed the same pus in the pleural cavity so about two inches of the 7th rib posterior axillary line was resected draining a large quantity of pus. He had developed a bronchial fistula and was in a marked state of shock but improved with stimulants and the use of oxygen-carbon dioxide mixture. A smear of the pus contained many gram negative cocci in chains; culture was negative.

During the next week he slowly improved but continued to cough up large quantities of purulent material; he also developed tubular breathing over the left apex anteriorly and posteriorly accompanied by many fine rales. He was transferred home on May 30 much improved with a temperature range of from 99 F. to 102 F., pulse 90 to 120 and respirations 30 to 40, but he continued a severe productive cough.

On June 4, the eleventh postoperative day, he coughed up a small amount of bright red blood and was given 300 cc. of whole blood by the citrate method. The next day we noticed an edema of the left chest wall extending upward from the incision into the neck and left side of the face. During the next few days this subsided somewhat, but at 4 a. m. June 8 he had a severe hemorrhage through the incision and was in a critical condition. He was transferred to the hospital and given 500 cc. of whole blood by citrate method which was repeated three hours later. In addition to this he received 1,000 cc. of 10 per cent glucose given slowly intravenously. Naturally the cause of hemorrhage was a subject of much speculation and concern and exploration of the incision was considered but was abandoned with the idea that it was probably coming from within the lung and not from an intercostal vessel although the latter was considered a possibility. It was noted next day that the edema of the chest wall and base of the neck had completely subsided.

On the following day the red blood count was 2,460,000 with 60 per cent hemoglobin (Sahli). The leukocyte count was 11,850 with 84 per cent polymorphonuclears. Urinalysis was negative except for an occasional pus cell. On June 10 the platelet count was 159,900, the clotting time 2 minutes 10 seconds, the bleeding time 2 minutes. On June 13 the red blood count was 3,210,000 with 60 per cent hemoglobin, the leukocyte remaining about the same. During the next ten days following the severe hemorrhage he experienced many violent coughing spells which were rather difficult to



control, but his general condition improved, his appetite was good and he seemed to gain strength. Examination of the chest revealed the same physical findings with persistence of rales over the left apex. The right chest remained clear. Drainage from the wound had changed from a chocolate color to that of a thick yellow pus. The drainage tube had been removed for a few days and replaced with one smaller and shorter.

Another transfusion was given on June 15 with 300 cc. of whole blood. He was thought to be doing well but on the night of June 18 he experienced another severe hemoptysis and was given 500 cc. of blood together with glucose (10%) and saline intravenously. The next night, June 19, he awakened from a sound sleep to cough, had another severe hemorrhage (by hemoptysis and from the wound) collapsed, and died.

#### AUTOPSY—EXAMINATION OF CHEST AND ABDOMEN

*Right Pleural Cavity:* The right lung was expanded and normal; there were a few pleural adhesions.

*Left Pleural Cavity:* The lung was collapsed; there were many dense pleural adhesions and the pleural cavity contained a moderate amount of foul, blood tinged pus. The apex of the lung was obliterated and occupied by a large abscess cavity communicating directly with the upper bronchus and the pleural cavity posteriorly. There was a recent resection of about two inches of the 7th rib posterior axillary line which afforded good drainage of the pleural cavity. There was a sinus leading from the apex through the cupula pleurae posteriorly to the clavicle and into the base of the left side of the neck, through which blood flowed freely on pressure from above. A section of the left lung did not reveal any demonstrable site of hemorrhage, neither did examination of the incision.

*Pericardium:* The pericardium was distended and contained about 200 cc. of clear straw colored fluid; the heart was dilated, the muscle very soft and flabby.

*Abdomen:* The liver was enlarged; other viscera were normal and there was no evidence of active infection.

- Diagnosis:* (1) Empyema of the left chest.  
(2) Abscess of the apex of left lung.  
(3) Secondary hemorrhage from unknown vessel in the base of left side of neck through a rupture of the left cupula pleurae.

#### DISCUSSION OF CASE

From a scientific and practical standpoint it is to be regretted that limitations placed on the autopsy permit prevented thorough dissection of the base of left side of the neck in an effort to determine the vessel involved in hemorrhage. We are able only to theorize but it seems most probable that either the subclavian vein or artery or one of their immediate branches was responsible. It is difficult to say whether the abscess of the left apex was present before or occurred as the result of the bronchial fistula which manifested itself just prior to the operation. From physical findings, however, it is believed that the abscess had been forming and was, as a matter of fact, responsible for development of the fistula. At any rate, the infective process continued to spread, involving the cupula pleura and tissues about the subclavian vessels, evidently weakening their walls, resulting in a rupture probably during a particularly violent coughing spell. After the initial hemorrhage a clue as

to its origin presented itself but was not recognized. This was the edema of left side of the neck, shoulder and of the chest wall of the same side. This swelling was definitely not an acute inflammatory process and was undoubtedly due to accumulation of blood in the tissues. Had it been recognized, treatment by means of resection of the clavicle with ligation of the vessel involved should have been considered.

#### CONCLUSION

An attempt has been made to outline the possible sources of hemorrhage complicating empyema of the chest together with report of a fatal case. Treatment depends upon diagnosing of the source which at times is most difficult if not impossible. All symptoms and physical findings should be carefully and orderly analyzed so that a more accurate diagnosis may be made. Fortunately, fatal hemorrhage occurs in probably less than one per cent of all deaths resulting from empyema.

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## OSTEOARTHRITIS

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Venice

In discussing the type of arthritis which appears with advancing years, it is well to identify this form of arthritis according to the terminology of different authorities.<sup>1</sup> Virchow describes it as "arthritis deformans," Goldthwaite calls it "hypertrophic arthritis," Nichols and Richardson term it "degenerative arthritis," and Ely describes it as "type II arthritis." I have elected to follow the English nomenclature and discuss this form of arthritis under the terminology of "osteoarthritis."

## AGE

Osteoarthritis is usually found in persons past middle life. It never affects young people. The age limit has been variously set at from 40 years of age to 70 and over. One sex is as frequently involved as the other.<sup>2</sup>

## CLIMATE

Apparently climate does not affect the onset nor the duration of the disease.

## ETIOLOGY

After a careful study of the various authorities quoted in a voluminous literature, one finally comes to the conclusion that the cause of osteoarthritis is unknown. There is one school that holds to the opinion that the etiological factor is a disturbance of the metabolism.<sup>3</sup> There is not a firm basis for this contention, other than the fact that in some of the cases there is found an increase in cholesterol and uric acid of the blood and, in a certain group, a lowered metabolic rate. Other than these findings, there is not much of importance that can be ascertained from the metabolic standpoint. There is another group which holds to the opinion that the etiological factor is trauma. This may be either endogenous or exogenous. The endogenous trauma is characterized as that which occurs through normal physiological action through the years. Exogenous trauma is from some external injury that directly affects the joints.

Osgood<sup>4</sup> states that though the etiology of osteoarthritis is unknown, there are certain

predisposing factors which must be considered. He lists these as follows: over-weight, faulty diets, poor elimination, endocrine deficiencies or disturbances, fatigue, diminished circulation and occupational trauma.

Regardless, however, of what the exact etiological factor may be, we know that this disease involves those in the upper brackets of life, and that there are definite findings both from a metabolic and a traumatic angle.

## PATHOLOGY

In discussing the pathology of osteoarthritis, we must be aware of the fact that this disease affects mainly the weight bearing joints, namely the knees, hips, spine, shoulders and the terminal pharyngeal joints. Around each of these joints there are soft tissues and bony changes. The soft tissue changes are found principally in the synovial membrane and capsule. In the early stages, there is practically no change in either of these structures. However, as the disease progresses,<sup>5</sup> there is a definite thickening and villous proliferation of the synovial membrane. This membrane may be thrown into folds at the periphery of the joint and become pedunculated and may break off, becoming loose bodies in the joints. This may be an explanation for the formation of the joint mouse. During these changes there is increased vascularity in the synovial membrane, and occasional areas of small cell infiltration. The greatest pathological changes, however, occur in the hyaline cartilage and the bone ends. Degenerative changes in the cartilage begin at its periphery and progress at times to such proportions that the bone ends may meet, producing an increased friction and, of course, pain. Osteophytes for which this disease is so characteristic, are formed, and may grow to such an extent that limitation of the joint may occur. There is no bony ankylosis and, as a rule, no deformity.

Bick<sup>6</sup> in studying a series of osteoarthritis, found that 77 of his cases presented varicose veins in the lower extremities, and he felt that the venous stasis occasioned by the varicosities bears a definite relationship to the pathology of osteoarthritis.

Garrod,<sup>7</sup> in 1907, pointed out that in osteoarthritis the blood supply to the extremities is characterized mainly by a sluggish venous circulation, and he felt that the density of the

<sup>1</sup>Read at the Florida Medical Center, Clinical Conference, Section on "Arthritis Symposium," Jan. 24, 1939, Venice, Florida.



bone end and the easy formation of exostoses near the articular surface at sites of internal static trauma is deducible from the presence of venous congestion. It cannot be said that the vascular system is an etiological factor in osteoarthritis, but it is reasonable to assume that the symptoms, the progress of deformity, and the disability are directly influenced by the state of circulation. Assuming this statement to be true, it has a direct bearing on the therapeutic measure which should be employed in the correction of this deformity.

Toynbee,<sup>8</sup> in the middle of the last century, pointed out the fact that the articular cartilages lie outside of the circulation of the blood, and that they must get their nourishment from the joint secretions.

Godsir<sup>9</sup> pointed out that there are no lymphatics in the structure of the hyaline cartilage, and he demonstrated that the absorption of the hyaline cartilage takes place because of the invasion of the cartilage by a cellulovascular tissue. The cartilate cells have no power of resistance, they become swollen and rupture, and the invading cells fill up the defect with fibrous tissue.

Redfern<sup>10</sup> pointed out the fact that hyaline cartilage never repaired an injury by the production of cartilage, but the defect was always filled by fibrous tissue.

#### DIAGNOSIS

From the standpoint of diagnosis, I would like to say here that I am discussing this text from the medical side and recommend that the orthopedist and internist cooperate closely in this class of cases. It is well to divide osteoarthritis into three groups—first, adipose; second, thyroid deficiency and menopausal; third, senile.

In the adipose type, osteoarthritis is likely to start before the age of forty. It usually affects the weight bearing joints, mainly the knees, the sacro-iliac joint and the lumbar spine. Heberden's nodes are rarely seen in this type. The obesity is usually of the girdle type. Low blood pressure is generally found, and in women menstrual disturbances are frequent. The glucose tolerance test is normal, and so is the blood cholesterol.

In a thyroid deficiency type, the patient has dry and coarse skin, dry and coarse hair, there is definite mental dullness, and complaint of easy fatigability. He complains of cold hands

and feet, lack of energy, and is usually underweight and chronically constipated. The blood pressure and basal metabolism are low. Blood cholesterol is usually high. Heberden's nodes are a prominent feature. In the menopausal type, the disease has its onset either during or after the menopause. The patient usually complains of vasomotor instability evidenced by variations in blood pressure, hot flashes and dizziness. None of these patients have an elevation of temperature.

In the senile group, the arthritis usually appears late in life, in persons past sixty years of age. It is usually accompanied by elevation of blood pressure, a lowered basal metabolism rate, arteriosclerosis and degenerative changes in the eyes, the kidneys and the brain. The usual complaint is pain. There is generally no joint swelling. X-ray examination reveals the exact diagnosis.

The usual finding common to all these types is pain in the joint affected. X-ray examination reveals lipping of the joint margin and osteophyte formation.

#### TREATMENT—(*Medical*)

In the treatment of osteoarthritis, it would be well to follow the classifications which I have outlined above.

First—adipose group. Naturally, the first step to take in this group would be the reduction of weight of the patient. This has to be done, however, with extreme care. I would first determine the basal caloric requirement of the patient. Having done this, I would then place her on a diet of five or six hundred calories below the basal requirement. I would watch her carefully so that she did not lose weight too rapidly, and did not form ketone products in the urine. I would give her additional vitamin products so as to maintain a vitamin balance in the body. Faulty elimination would be corrected, and any endocrine disturbance treated. If the affected joint were acute, I would put her to bed, and give absolute rest to the part. Local applications of heat to induce better circulation and, at the proper time, the fitting of braces and physiotherapeutic measures would be employed.

Second—the thyroid deficiency group and menopausal syndrome group may be considered together. In this group, there is more apt to be a deficiency in thyroid function than in the other groups. If this is true, the proper

administration of thyroid to bring and maintain the metabolic rate within normal limits is often extremely beneficial. It is often miraculous that in the purely thyroid group, the administration of thyroid will bring about a subsidence in the joint symptoms and loss of pain. In the purely menopausal group, if there is a deficiency of the pituitary and ovarian factor, proper measures should be instituted to correct this.

We have noticed here among our group of cases, a very definite thyroid deficiency. The nails become very brittle, etc., and we take this to mean a very definite evidence of lack of cystine content and the necessity of sulfur therapy.

Third—senile group. Since this group constitutes the advanced age group, it would be wise to make a thorough constitutional check of the patient. If the gastric analysis showed a deficiency in acid, then dilute acid should be given to the patient's tolerance. If there is a deficiency in thyroid, then thyroid should be administered to increase the general metabolic rate. I would like to say here that all of you have evidently noticed as we have, from our experience, that thyroid administration is very important. Some can tolerate larger doses of thyroid than others. Chronic constipation should be eliminated, and physiotherapeutic measures instituted to increase the metabolic deficiency of the skin.

I do not subscribe to the wholesale extraction of teeth, enucleation of tonsils, removal of gallbladder and appendices, unless it can be proved that there is an existing focus of infection which is causing an exacerbation of symptoms or affecting the patient's general health.

#### *(Surgical)*

The rôle of the orthopedist must be closely associated with that of the internist in the proper handling of these cases. His part should be the proper direction of physiotherapeutic regimen, the application of braces, and, in the persistent painful joints, surgical measures for the relief of pain.

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10. Redfern: *Ibid.*

### ETHMOIDITIS

N. W. GABLE, M. D.  
St. Petersburg

The object of this paper is not to discuss the common findings of ethmoiditis but rather the more obscure aspects of this disease.

The diagnosis of chronic infection of the ethmoid sinus is one of the most difficult problems in rhinology. It is particularly difficult in those low grade chronic infections of the ethmoid sinus in which the nasal passages appear normal on one or more examinations and in which symptoms pointing directly to the sinus are so slight as to be almost nonexistent. (Shambaugh).

Let us touch hurriedly on the embryology and development of the paranasal sinuses. The anlage of the entire sinus system arises from the lateral wall of the septum, becomes separated from it in prenatal life and is eventually located on the lateral wall as the ethmoid anlage. In the program of growth it is shown that all of the paranasal sinuses, except the sphenoid, originate from this ethmoidal anlage in the olfactory region. This development accounts for the numerous dehiscences of the ethmoid into the various paranasal sinuses, showing the close connection of the ethmoid to the other sinuses. Also, for this reason, when an ethmoid infection is suspected, it is well to look closely into the other sinuses because of the extension of the infection from the ethmoid into the surrounding sinuses, and also from the sinuses that surround the ethmoid into the ethmoid cavity itself.

The ethmoid cells, varying in number from 2 to 15, are divided clinically into two groups, namely, the anterior and posterior cells. The

Read before the Pinellas County Medical Society, St. Petersburg, Sept. 1, 1939.



anterior are separated from the posterior by a thin, transverse, bony partition. The attachment of the turbinated body to the external wall of the nose marks the line of division between the anterior and posterior cells. The anterior cells lie in front of and below it, while the posterior cells lie behind it. There is an occasional accessory ethmoid sinus that lies in the middle turbinate and in the uncinate process. When this is present it drains into the middle meatus and belongs to the anterior group. The anterior cells drain into the region of the middle meatus, while the posterior cells drain over the posterior tip of the middle turbinate through the olfactory fissure into the posterior nares.

The ethmoid cells are innervated primarily through the sphenopalatine ganglion, and also from the ophthalmic division of the trigeminus, which carries the sensory impulses from the ethmoid cells, sphenoid cells and corresponding portions of the septum. The sphenopalatine ganglion is situated in the upper part of the pterygopalatine fossa, which lies just posterior to and immediately above the posterior tip of the middle turbinate. Due to this innervation, various obscure pains in the different parts of the head may have their origin in the ethmoid region.

Diagnosis of chronic ethmoiditis is, in my opinion, particularly hard due to the fact that transillumination and x-ray are often of little value, and also because frequently there are very few signs of a chronic infection, such as pus in the middle of the meatus or signs of polypoid degeneration. Some of the more obscure symptoms of ethmoiditis are pain in the cheek, ethmoid region, forehead, parietal region, or in the region around the mastoid or in the ear. These pains come from an irritation through the sphenopalatine ganglion and are referred to these regions. Characteristic of sinus pains, they are worse following an acute infection in the nose, or on bending the head forward, or a sudden change in temperature. We quite often see these symptoms and yet the nasal passage appears clear.

One of the most annoying symptoms of ethmoiditis is what is known as Sluder's syndrome, which is a neuralgia of the sphenopalatine ganglion, causing pain which begins at the root of the nose, in and about the eye, upper jaw and teeth, and extends backward

to the temple and around the ear. This condition usually follows either an acute or chronic infection of the ethmoid cells and is due to an irritation in the sphenopalatine ganglion, which supplies these regions. Symptoms are also produced by obscure low grade ethmoid infection in remote organs, such as iritis, neuritis, and arthritis. It is quite often the case that enough absorption is obtained from the chronic infection in the ethmoid to produce these manifestations, and still the region of the ethmoid may seem clear on inspection.

Another obscure symptom is chronic cough. It has not been definitely decided whether this cough is a reflex cough from an irritation through the sphenopalatine ganglion, or from a direct extension of the low grade infection into the bronchioles. We have noted on several occasions that these persistent coughs could be definitely improved by proper treatment of the ethmoid region. Probably the most definite symptom of chronic ethmoiditis is that of frequent acute colds, in which the middle and inferior turbinates become so congested that it is almost impossible to get air through them. These colds come on in more or less regular intervals and without apparent cause. We have found that by properly treating the ethmoid region and cleaning out any chronic infection that might be present, we have definitely reduced the incidence of these colds.

The treatment of this chronic sinus disease has gone through almost all of the stages from palliative to radical surgery. However, I am glad to report at the present time the radical surgical treatment is gradually going out of vogue, and the palliative treatment is becoming more popular. The treatment with which I have had the best results consists of shrinking the mucous membranes of the middle and inferior turbinates, and also around the ostium of the ethmoid sinuses to allow free drainage. Even in this form of treatment the trend is toward less drastic measures. Realizing that the mucous membrane in the nose is a delicate structure, we are getting as far as possible away from the use of extremely irritating drugs. There are several treatments recommended. In the Proetz treatment, the patient's head is placed in a hyperextended position and the nasal passage filled with a  $\frac{1}{4}$  of 1 per cent ephedrine in physiologic solution of sodium chloride; then

a gradual suction and release is applied to the nostril. In this way, pus and mucus from the ethmoid cells are evacuated with a definite shrinking of the ostia.

One of the most satisfactory treatments, both to the patient and to the doctor, is the placing of tampons saturated with a colloidal silver solution in the region of the ethmoid cells. These tampons are placed both under the middle turbinate so as to reach the anterior cells and over the middle turbinate so as to reach the posterior cells. By osmosis they remove the excess fluid from the mucous membrane, thus causing a definite shrinking, allowing better breathing through the nose, and a better drainage from the ethmoid cells; at the same time implanting into the tissues small quantities of the colloid, which is in itself a germicidal agent. It is sometimes necessary to remove a portion of the middle turbinate in order to make the applications of the tampons in the vicinity of the cells. This area of the nose is spoken of as the "trigger," because it is here that a large number of the symptoms of bronchial asthma arise. We have found that in most asthmatics there is a definite infection in this area, and by cleaning it out we have been able to relieve the bronchospasms.

Cocainization of this area of the nose will definitely relieve the majority of the above mentioned symptoms, but this treatment should be handled very carefully, as this is the beginning of the majority of cocaine addicts, and I believe where it is possible to use any other drug for this treatment it should be done for this reason. The use of ephedrine and adrenaline in the nose should be discouraged as much as possible, especially the indiscrimi-

nate use of these drugs as sold over the drug counter on call from the patient. We know that the prolonged use of these drugs, especially in an oily base, has caused considerable damage to the mucous membrane of the nose, and although they may be used in moderation in acute nasal disease, these drugs should be used under the advice of a physician and not continued indefinitely.

706 Power & Light Bldg.

## PLANS FOR ARMY MEDICAL LIBRARY

"Constantly in abeyance for almost a decade has been the proposal to erect a new building for the Army Medical Library and Museum in Washington, D. C.," *The Journal of the American Medical Association* for March 16 declares. It adds:

Now the path has been cleared, a site has been found near the Library of Congress, and all that is necessary is the final appropriation.

The collection of medical works in the Army Medical Library is one of the finest in the world; indeed, it is thought by many to deserve the absolute superlative. Yet it is housed today in an ancient structure, a veritable fire trap, in which an accident of some type might bring about catastrophic destruction of material which could never be replaced. Certainly if ever a need existed for expenditure of money for some real purpose, it exists in relation to the necessity for building a new home for this invaluable scientific medical collection.

Recently the Librarian of Congress, Archibald MacLeish, was asked his opinion of the Army Medical Library. His reply was "The Surgeon General's Library is one of the greatest special collections of books ever put together, if not indeed the greatest, and its present lack of housing holds tragic possibilities for American learning and for the good repute of American learning." In the very near future Congressional hearings will be held on this project. Every physician may well afford to lend his voice to the appeal for immediate action.



VIEW OF TERRAZZO DANCE FLOOR AND GOLF COURSE



## Tampa – The Convention City



AIR VIEW OF CITY AND PORTION OF DAVIS ISLANDS

The Old vies with the New in Tampa. The visitor's appreciation of the cosmopolitan and Old World atmosphere of this interesting city will be enhanced by a visit to the Latin sections. Here one may glimpse an attractive *senorita* and enjoy a leisurely Spanish feast, served course by course, cooked and seasoned as only an expert Spanish chef knows how.

In contrast to the languor of the Latin sections there is the man-made exclusive residential area, Davis Islands. One mile from downtown Tampa, dredged from the Bay, is a group of islands surrounded by eleven miles of seawall and intertwined with canals. On the islands will be found modern hotels and apartments, country club, golf course, tennis club, swimming pool and many beautiful residences. At the southern end of this 800 acre development is located the Peter O. Knight Airport, combination land and seaplane base from which giant clippers will some day take off on their South American flights.

In Tampa one can play on a different golf course every day in the week. Salt water

fishing trips out in Old Tampa Bay with competent guides can be arranged for any number of persons and fresh water bass fishing is available most of the year in the many lakes of Hillsborough and neighboring counties.

Every visitor to Tampa should visit beautiful Plant Park with its huge oaks, many varieties of towering palms, and other trees and subtropical foliage too numerous to mention. Here is the DeSoto Oak under which its namesake is said to have made his treaty with the Indians. Here also is the University of Tampa, formerly the Tampa Bay Hotel, a co-educational institution with over 700 students. The large structure is of Moorish design topped by thirteen minarets and domes, each surmounted by a gilt crescent, making in all a complete lunar year. To the wanderer returning home, Tampa's skyline would be incomplete without these crescented towers etched against the setting sun. The "breakfast promenade" from one end of the building to the other is 1,250 feet long and the walk around the outside is exactly one mile. The



HEADQUARTERS HOTEL

roof contains  $6\frac{1}{2}$  acres. In the south wing of this fascinating edifice is the city museum of 18 rooms containing many valuable paintings, statues and curios gathered by Mr. and Mrs. Plant from the four corners of the earth.

Tampa's attractive Tourist Recreation Center is at the north end of Plant Park and the Florida Fair Grounds are just west of the Park.

Visitors from all parts of the country have steadily built up tourist registrations, which show an increase of five hundred per cent during the last five years, an average increase of one hundred per cent a year.

Tampa is the world's largest producer of clear Havana cigars, over 100 factories manufacturing 374,627,804 cigars during 1938, and its port, ranking sixteenth for the United States in export tonnage, ships much phosphate, lumber and citrus fruit. The Tampa area produces seventy-five per cent of the country's phosphate. During the last few years this city has become the center of the citrus canning industry and the canning of vegetables is increasing very rapidly.

At present Tampa is entering into what appears to be the most prosperous era of its

history, since \$30,000,000 is to be spent on various developments during the next few years. Tampa's 5,500 acre Army Air Base, to be built at a cost of \$10,000,000 is now under construction; \$15,000,000 in United States Shipping Board contracts have been let to its shipyard; \$2,200,000 more is to be spent on a Federal Housing Project; and another \$1,500,000 has been appropriated for a Spanish War Memorial on Davis Islands.

While attending the Florida Medical Association Convention you will be interested



SKYLINE FROM BANKS OF HILLSBOROUGH RIVER

to see and drive on Tampa's new six-lane concrete boulevard and parkway on the Bayshore and to visit the new Southeastern Army Air Base.

For any other information concerning the city not obtainable at headquarters registration desk, phone the Tourist Information Bureau, H-1444, or the Chamber of Commerce, M-8011, where your requests will receive courteous attention.



# PROGRAM

of the

## SIXTY-SEVENTH ANNUAL MEETING

of the

### FLORIDA MEDICAL ASSOCIATION, Inc.

TO BE HELD AT TAMPA, FLORIDA

APRIL 29, 30, AND MAY 1, 1940

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#### REGISTRATION

The registration desk will be located on the mezzanine of the Tampa Terrace Hotel, with continuous service throughout the meeting. All members will be required to register and secure identification badges before attending any of the sessions. Guests and ladies are required to register. Tickets for the dinner, Tuesday evening, April 30, may be obtained at the hotel desk.

#### HOTELS

TAMPA TERRACE—*Convention Headquarters.*  
(European Plan)

Single - \$3.00                      Double - \$5.00

|                                      | Single | Double |
|--------------------------------------|--------|--------|
| Floridan, Fla. Ave. and Cass St..... | \$3.00 | \$5.00 |
| Bay View, 208 Jackson St.....        | 2.50   | 4.50   |
| Hillsboro, Twiggs and Fla. Aves..... | 2.50*  | 3.50*  |
| Thomas Jefferson, Frank. and Wash... | 2.00*  | 3.50*  |
| Mirasol, Davis Island.....           | 2.50   | 4.00   |

\*And up.

#### TECHNICAL EXHIBITS

Technical exhibits will be located on the mezzanine of the Tampa Terrace Hotel.

The technical exhibits have a real scientific value and physicians who wish to keep abreast of the times and know the latest in drugs and medical appliances should spend some time with these exhibits. A surprising amount of useful information can be procured at these exhibits. Many have nothing for sale, the representatives of the firms being there to give the latest information regarding their products. Those who have items for sale will gladly give information whether there is a purchase or not. Be sure to register your name with the various representatives who are exhibiting.

The following firms have arranged for exhibits at the Tampa meeting:

A. S. Aloe Company  
American Optical Company  
Bard-Parker Company, Inc.  
The Coca-Cola Company  
Citrus Concentrates, Inc.  
Cutter Laboratories  
Everhart Surgical Supply Co.  
H. G. Fischer & Company  
C. B. Fleet Co.  
Florida Citrus Commission  
General Electric X-Ray Corp.  
Keleket X-Ray Co. of Florida  
Lederle Laboratories, Inc.  
Eli Lilly & Co.  
J. B. Lippincott Company

M & R Dietetic Laboratories  
Mead Johnson & Company, Inc.  
The Wm. S. Merrell Company  
Miami Surgical Co.  
C. V. Mosby Company  
Nestle's Milk Products  
Parke, Davis & Co.  
Pet Milk Sales Company  
Petrolagar Laboratories, Inc.  
Philip Morris & Co., Ltd., Inc.  
Sharp & Dohme, Inc.  
Smith, Kline & French Laboratories  
Southeastern Optical Company  
E. R. Squibb & Sons  
Standard X-Ray Company  
Surgical Supply Company  
Table Rock Laboratories  
Westinghouse X-Ray Company, Inc.

#### SCIENTIFIC EXHIBITS

The scientific exhibits will be located on the second floor of the Tampa Terrace Hotel, Rooms 208, 210 and 212.

We consider ourselves fortunate to be able to present for your approval the following exhibits:

1. Jacques W. Maliniac, M. D., New York City.  
Plastic and Reporative Surgery of Post-traumatic Disfigurements. Colored photography and motion pictures. (Room 212).
2. Pathological Department of Jackson Memorial Hospital, Miami.  
Dr. Philipp Rezek, pathologist, Pathological exhibit. (Room 208).
3. J. Maxey Dell, Jr., M. D., Gainesville.  
X-ray films on sinus disease in infants and children. (Room 210).

#### FISHING TRIPS

Half-day fishing trips for parties of four to six will be arranged for the convenience of those interested in this sport. Parties will be taken on half-day trips arranged for either mornings or afternoons from the Gandy Bridge or Pass-A-Grille. Applicants for fishing trips will be consulted with regard to the time most convenient to them. Those not making previous application will also be given an opportunity to register for trips soon after their arrival in Tampa, at the information desk in the main lobby of the Tampa Terrace Hotel. Application should be made to Dr. William C. Blake, Chairman Anglers' Committee, 706 Franklin Street, Tampa.

## GOLF

The Annual Handicap Golf Tournament for members of the Florida Medical Association will be played at the Palma Ceia Golf Club. The Tournament will be held on Monday and Tuesday, April 29 and 30. The Club will be available to members of the Association for practice rounds on Saturday and Sunday, April 27 and 28. Those wishing to participate must have registered and show F. M. A. badges. Greens fee will be \$1.00.

Rules: U. S. Golf Association. See card for local rules.

Handicaps: Three-fourths official handicap with a maximum of 27 strokes. The entrant must register with the starter and give his handicap before beginning his Tournament round.

Score card must be dated, signed, attested and turned in to the starter at the end of the round.

First Prize: Orlando Cup (low net score).

Other prizes will be awarded for the low net and best 9.

For those who desire it luncheon will be served at the Club House.

For additional information communicate with Doctor J. C. Dickinson, Chairman, Golf Committee, Citizens Bldg., Tampa.

## SKEET AND TRAPSHOOTING

Skeet and Trapshooting events will take place at the Forest Hills Country Club on Sunday, April 28, and Tuesday, April 30, at 3 p.m. Trophies will be awarded to all classes. Charges will be made for shells and birds. Arrangements should be made in advance but those who have not made previous arrangements will be given an opportunity to register immediately upon their arrival in Tampa, at the information desk in the main lobby of the Tampa Terrace Hotel. All applications to participate in this sport should be made to Dr. Joseph W. Taylor, Chairman of Trapshooters' Committee, 810 Citizens Building, Tampa.

## ALUMNI AND FRATERNITY LUNCHEONS

The Committee in charge of Alumni and Fraternity Luncheons has made arrangements with the Tampa Terrace Hotel to provide rooms for any group of doctors who desire to have lunch together. All doctors who plan to attend an Alumni or Fraternity luncheon should communicate at once with Dr. Blackburn Lowry, Citizens Building, Tampa.

## EMORY ALUMNI BANQUET

Notice to Emory University Medical Alumni: It is urged that all Emory University Medical Alumni arrange to attend the Alumni Banquet during the State Medical Association meeting in Tampa. Please communicate with, or contact, Dr. James L. Estes, vice-president of the Florida Emory University Medical Alumni, 815 First National Bank Bldg., Tampa.

OFFICERS OF HILLSBOROUGH COUNTY  
MEDICAL SOCIETY

JOHN R. BOLING, *President*

JULIEN C. PATE, *Vice President*

JAMES S. GRABLE, *Secretary-Treasurer*

## LOCAL COMMITTEES

## Cabinet

John R. Boling, *Chairman*

|                     |                       |
|---------------------|-----------------------|
| William P. Adamson  | David R. Murphey, Jr. |
| William C. Blake    | Robert G. Nelson      |
| George L. Cook      | William M. Rowlett    |
| Joshua C. Dickinson | H. Mason Smith        |
| James L. Estes      | Joseph W. Taylor      |
| Eugene S. Gilmer    | John C. Vinson        |
| Blackburn W. Lowry  |                       |

## Registration

George L. Cook, *Chairman*

|                   |                  |
|-------------------|------------------|
| Edgar Austin      | Burdette Smith   |
| A. M. Bidwell     | Edward Smoak     |
| S. H. Etheredge   | Ralph S. Torbett |
| William Patterson | E. Bryant Woods  |

## Hotels

James L. Estes, *Chairman*

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|--------------------|------------------|
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| John W. Alsobrook  | Tilden H. Phipps |
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| W. J. Holton       | E. F. Shaver     |
| Douglas G. Meighen |                  |

## Lantern-Amplifier

Eugene S. Gilmer, *Chairman*

|                 |                   |
|-----------------|-------------------|
| Emory W. Bitzer | Nathan L. Marcus  |
| Herbert B. Lott | Joseph D. Scolaro |
| George R. Maner |                   |

## Association Dinner

D. R. Murphey, Jr., *Chairman*

|                 |                   |
|-----------------|-------------------|
| A. R. Beyer     | Stephen P. Gyland |
| Lester J. Efrid | Herbert R. Mills  |
| Charles M. Gray | Glenn E. Stayer   |

## Stag Smoker

William P. Adamson, *Chairman*

|                      |                    |
|----------------------|--------------------|
| Chadbourn A. Andrews | Hugh E. Parsons    |
| Leland F. Carlton    | Joseph S. Spoto    |
| Julio J. Guerra      | Joseph N. Torretta |
| A. R. Knauf          |                    |

## Golf

Joshua C. Dickinson, *Chairman*

|                    |                  |
|--------------------|------------------|
| Frank S. Adamo     | James T. Cowart  |
| H. J. Blackmon     | Reuel A. Ely     |
| Virgil M. Bradshaw | Louis J. Garcia  |
| H. M. Cook         | Clack D. Hopkins |

## Anglers'

W. C. Blake, *Chairman*

|                    |               |
|--------------------|---------------|
| E. F. Carter       | John H. Mills |
| Americo J. Ferlita | H. O. Snow    |
| Sherman B. Forbes  | A. S. Weekley |
| B. Martin McClosky |               |

## Trapshooters'

Joseph W. Taylor, *Chairman*

|                   |                 |
|-------------------|-----------------|
| Fay A. Cameron    | Ralph T. Heath  |
| William J. Davis  | A. M. C. Jobson |
| William P. Duncan | John T. Moore   |
| Walter H. Dyer    |                 |

## Finance

Robert G. Nelson, *Chairman*

|                 |                   |
|-----------------|-------------------|
| Harold O. Brown | Douglas D. Martin |
| James S. Grable | L. B. Mitchell    |

## Greeters'

H. Mason Smith, *Chairman*

|                   |                       |
|-------------------|-----------------------|
| Frank T. Barker   | Frank C. Metzger      |
| John S. Helms     | Thomas F. Nelson      |
| Rollin Jefferson  | Harold G. Nix         |
| Thos. C. Maguire  | Nathaniel L. Spengler |
| Charles R. Marney | Harper E. Whitaker    |



*Ladies' Advisory*

William M. Rowlett, *Chairman*

|                   |                    |
|-------------------|--------------------|
| Giulio C. Bottari | Rosalind Ebersbach |
| Edith M. Corlew   | R. Bradner Mertz   |
| Arthur D. Draper  | Sheldon Stringer   |

*Alumni and Fraternity Luncheons*

Blackburn W. Lowry, *Chairman*

|                 |                    |
|-----------------|--------------------|
| Robert C. Black | R. Renfro Duke     |
| T. R. Butchart  | Horace A. Knowlton |
| John A. Coleman | Alvord L. Stone    |

*Transportation*

John C. Vinson, *Chairman*

|                    |                |
|--------------------|----------------|
| Milo H. Holden     | Wade C. Myers  |
| E. W. Holloway     | Joseph Ruskin  |
| W. B. Hopkins      | D. L. Sprinkle |
| James R. McEachern |                |

**MONDAY**

**REFERENCE COMMITTEES, HOUSE OF DELEGATES (Subject to Approval)**

*Private rooms have been provided for meetings of reference committees in the Tampa Terrace Hotel. Each reference committee's room number is designated. The chairman of each reference committee is requested to announce, as well as post on the bulletin board in the hotel lobby, the time his committee will meet. Should additional meetings of reference committees be held, the time of such meetings should be made known to the members in the same manner.*

**NO. 1, HEALTH AND EDUCATION**

Room 205

| <i>Member</i>         | <i>Representative of</i> |
|-----------------------|--------------------------|
| W. C. Jones, Chairman | Scientific Work          |
| T. Z. Cason           | Postgraduate Course      |
| J. M. Hoffman         | Cancer Control           |
| E. T. Sellers         | V. D. Control            |
| M. J. Flipse          | T. B., Pub. Health       |
| F. Richards           | Maternal Welfare         |
| W. W. Quillian        | Child Health             |
| H. A. Barge           | Necrology                |

**NO. 2, PUBLIC POLICY**

Room 207

| <i>Member</i>          | <i>Representative of</i> |
|------------------------|--------------------------|
| H. A. Walker, Chairman | Medical Economics        |
| H. A. Day              | Leg., Pub. Policy        |
| J. R. Chappell         | Education-Hospitals      |
| J. R. Wells            | Public Relations         |
| E. C. Swift            | Inter-Relationship       |
| G. A. Dame             | State Institutions       |
| G. H. Ira              | Advisory-Auxiliary       |
| A. H. Weiland          | Industrial Council       |

**NO. 3, FINANCE**

Room 214

| <i>Member</i>               | <i>Representative of</i> |
|-----------------------------|--------------------------|
| Shaler Richardson, Chairman | Executive                |
| G. S. Osincup               | Executive                |
| G. L. Cook                  | Executive                |
| L. M. Limbaugh              | Executive                |
| W. C. Payne                 | Executive                |
| J. S. Stewart               | Executive                |
| W. C. Thomas                | Executive                |
| L. F. Robinson              | Executive                |
| Herman Watson               | Council                  |
| J. H. Pierpont              | Past Presidents          |

**FIRST MEETING OF HOUSE OF DELEGATES**

*Monday, 1:30 p. m.*

CHAMBER OF COMMERCE BUILDING

President Robinson in the Chair.

Roll Call and seating of delegates.

Adoption of minutes as published in June, 1939 Journal.

Approval of reference committees as printed in program.

Recognition of delegates to A. M. A.: Herbert L. Bryans and Meredith Mallory (*official report read at meeting of Executive Committee*).

Election of one delegate and one alternate to A. M. A. meeting for two-year terms.

(*A. M. A. By-Laws, Chapter 1, Sec. 1: "A member of the House of Delegates must have been a member of the American Medical Association and a Fellow of the Scientific Assembly for at least two years next preceding the session of the House of Delegates at which he is to serve."*)

Reading of Resolutions.

Meeting Place, 1941. (*Recommendation of Executive Committee*).

Reports of Committees:

(*Two copies of each report to be laid on speaker's table immediately after reading.*)

Executive, Gilbert S. Osincup

Scientific Work, Walter C. Jones, Jr.

Publication, Walter C. Jones Jr.

Legislation and Public Policy, Horace A. Day

Medical Education and Hospitals, J. Rocher Chappell

Public Relations, J. Ralston Wells

Necrology, Hubert A. Barge

Medical Postgraduate Course, T. Z. Cason

Cancer Control, James M. Hoffman

Medical Economics, H. A. Walker

Venereal Disease Control, E. T. Sellers

Inter-Relationship, Edwin C. Swift

Tuberculosis and Public Health, M. Jay Flipse

State Controlled Medical Institutions, G. A. Dame

Maternal Welfare, F. Richards

Child Health, Warren W. Quillian

Advisory to Woman's Auxiliary, G. H. Ira

Council, Herman Watson

Representatives to Industrial Council, A. H. Weiland

Board of Past Presidents, J. H. Pierpont

New Business.

Announcements.

Adjournment.

**FIRST GENERAL SESSION**

*Monday, 4:30 p. m.*

PALM ROOM

Call to Order, President Leigh F. Robinson

Invocation, The Rev. John B. Walthour

Address of Welcome, John R. Boling,

President Hillsborough County Medical Society.

President's Address, Leigh F. Robinson, Ft. Lauderdale

Report of Secretary-Treasurer-Editor, Shaler Richardson and Managing Director, Stewart Thompson.

Report of our Delegates to Medical Association of Georgia Convention:

Homer L. Pearson

Gerry R. Holden

Introduction, Delegates from other State Societies:

W. W. Anderson, Atlanta,

John W. Brittingham, Augusta,

T. C. Davison, Atlanta.

New Business.

Announcements.

## SCIENTIFIC ASSEMBLIES

Committee on Scientific Work: Walter C. Jones, Chairman, Miami; Leland F. Carlton, Tampa; Robert B. Harkness, Lake City; John S. McEwan, Orlando; James H. Pound, Tallahassee; Herbert E. White, St. Augustine.

Attention is called to the following By-Laws:

"All papers read before the Association shall be its property. Every paper shall be deposited with the Secretary when read."

"No address or paper before the Association, except those of the President and Orator, shall occupy more than fifteen minutes in its delivery, and no member shall speak longer than five minutes, or more than once on any one subject."

## PROJECTORS

The Committee on Projecting Lantern, of which Dr. Eugene S. Gilmer is Chairman, has arranged for a projecting lantern and daylight screen for use during the convention. An operator will be available at all times.

## FIRST SCIENTIFIC ASSEMBLY

Monday, 7:00 to 8:30 p. m.

## PALM ROOM

1. "Infection of Nasal Accessory Sinuses in Childhood" (lantern slides), Warren W. Quillian, Coral Gables.

Suggestive signs and symptoms; review of anatomy and physiology. Diagnosis and illustration with x-ray studies. Treatment with special reference to medical care.

Discussion: Douglas D. Martin, Tampa;  
C. E. Dunaway, Miami.

2. "Management of the Breast Fed Baby, Including Immunization Procedures," Ludo von Meysenbug, Daytona Beach.

Breast milk is still the best food for the baby. Discussion takes up nursing technic, colic, vomiting, pylorospasm and stenosis of the pylorus. Other foods and proper ages at which to give them. Best ages at which to give various immunizations for pertussis, diphtheria, smallpox, together with the preparations used, are dealt with.

Discussion: Luther W. Holloway, Jacksonville;  
Councill C. Rudolph, St. Petersburg.

3. "Absorption of Quinine into the Cerebrospinal Fluid of the Fetus in Utero," (Lantern Slides), H. Marshall Taylor, Lucien Y. Dyrenforth, Jacksonville, and C. B. Pollard, Gainesville.

Report of original research. Quinine administered in the induction of labor. At birth of fetus, cerebrospinal fluid is obtained and an analysis of the cerebrospinal fluid of the infant shows the presence of quinine.

Discussion: S. B. Forbes, Tampa;  
L. C. Ingram, Orlando.

## STAG SMOKER

Monday, 9 p. m.

## PALMA CRIA GOLF CLUB

## TUESDAY

## PAST PRESIDENTS' BREAKFAST

Tuesday, 7:30 a. m.

## TERRACE LOUNGE DINING ROOM

## SECOND SCIENTIFIC ASSEMBLY

Tuesday, 9 to 11:55 a. m.

## PALM ROOM

4. "Impetigo Contagiosa Complicated by Hemorrhagic Nephritis; Case Reports," Henry E. Palmer, Tallahassee,

A report of five cases of impetigo contagiosa with the rather infrequent complication of hemorrhagic nephritis in children from four to seven years of age.

Discussion: Thomas M. Palmer, Jacksonville;  
Gilbert S. Osincup, Orlando.

5. "The Medical Man and the Workmen's Compensation Law," E. Laurence Scott, Ocala.

Outline of Florida Compensation Law, its intent and application. Classification of injuries and estimates of disabilities. The medical man's obligation to the insurance carrier, the employer and the employed. The language of the Law as directed to medical men. Results of the Law's application, economically and medically considered. Experiences gained by the writer from applications of the Law, viewed through a medical man's eyes.

Discussion: Harry F. Watt, Ocala;  
Prescott LeBreton, St. Petersburg.

6. "A Consideration of Climate and Altitude in the Treatment of Hypertension and Myocardial Failure," D. Paul Bird, Lakeland.

Essential hypertension and myocardial failure are both similar to conditions of anoxemia seen in studies of aviation medicine. Climate and altitude influence the treatment of essential hypertension and myocardial failure. A warm, subtropical climate of low altitude and moderate humidity affords the best climatic conditions for the treatment of both.

Discussion: James A. Bradley, St. Petersburg;  
H. A. Day, Orlando.

7. "Heart Disease" (Symposium)

- a. "Some Observations on Coronary Occlusion," Roscoe H. Knowlton, St. Petersburg.

Coronary thrombosis may be rapid with severe pain and shock or slow with pain entirely absent, causing it to pass unrecognized. A sudden occlusion may be painless as when it occurs when patient is under full anesthesia. Difficulty of diagnosis when symptoms referred mainly to gastrointestinal tract, abdomen and to the respiratory system. Treatment.

- b. "Correlating History, Clinical and Electrocardiographic Findings in the Diagnosis of Coronary Occlusion," T. Z. Cason, Jacksonville.

Accumulated data show that the electrocardiogram may not reveal any evidence of the occlusion for several days after it occurs; that the electrocardiogram may be misleading both as to the diagnosis and the prognosis; and that not infrequently electrocardiographic evidence of changes in the coronaries is mistaken for coronary occlusion. Further, the expected drop in blood pressure does not always occur. The history of substernal pain simulating indigestion is sometimes really indigestion. The vital importance of correct diagnosis.

- c. "Aftermath of Coronary Disease," E. Sterling Nichol, Miami.

Discussion: W. C. Blake, Tampa;  
E. W. Bitzer, Tampa;  
R. M. Harris, Miami;  
Thomas E. Daly, Palm Beach.



THIRD SCIENTIFIC ASSEMBLY

*Tuesday, 1:30 to 4:30 p. m.*

PALM ROOM

8. "Chronic Empyema," (Lantern Slides), J. W. Snyder, Miami.

Two cases of chronic empyema, each of fifteen years' duration, are to be discussed, each case presenting a different problem and a different surgical approach. General observations as to the causation and prevention of chronic empyema will also be discussed.

Discussion: Leland F. Carlton, Tampa;  
Frank G. Slaughter, Jacksonville.

9. "Thoracoplasty Program at the Florida Tuberculosis Sanatorium; Preliminary Report," (Lantern Slides), L. H. Kingsbury and W. O. Fowler, Orlando.

Study of sixty-six thoracoplasty cases, beginning with historical aspects of this form of collapse, briefly: technique, indications, preoperative and postoperative care and trends in results. Designed to cover thoracoplasty program as applied at the State Sanatorium from May, 1938, through April, 1940, not including the end results because of insufficient time elapsed in a majority of these cases to demonstrate ultimate outcome.

Discussion: Kenneth A. Morris, Jacksonville;  
Duncan McEwan, Orlando.

10. "Therapeutic Evaluation in Cases of Cryptorchidism," (Lantern Slides), Louis M. Orr, II, and Palmer R. Kundert, Orlando.

Several years have now elapsed since the introduction of hormone therapy in cases of cryptorchidism. This paper reviews the literature in regard to the proper selection of cases for the different forms of therapy and presents in greater detail the surgical treatment of undescended testicle.

Discussion: Roy J. Holmes, Miami;  
E. S. Gilmer, Tampa.

11. "Metycaine as a Caudal Anesthetic in Proctologic Surgery; Report of 100 Cases," (Lantern Slides), Claude G. Mentzer, Miami.

This is a report of 100 unselected proctologic cases in which metycaine was used as a caudal anesthetic. Anesthesia was perfect in 90 cases and partial in 10. The time necessary to obtain anesthesia was short. There were no complications ascribable to this agent. Such a safe, efficient drug and method should be used more frequently for operative procedures about the perineum, anus, rectum and genitalia.

Discussion: Leigh F. Robinson, Ft. Lauderdale;  
C. Larimore Perry, Miami.

12. "The Syndrome of the Dislocated Intervertebral Disc; Diagnosis and Treatment," (Lantern Slides), J. G. Lyster, Jacksonville.

Clinical symptoms and findings of ruptured nucleus pulposus or herniated intervertebral disc, which are usually the same as those of sciatica. Diagnostic tests, especially the use of lipiodol and oxygen myelography, will be discussed. Treatment, especially from the neurosurgical standpoint.

Discussion: J. A. Beals, Jacksonville;  
Prescott LeBreton, St. Petersburg.

SECOND MEETING OF HOUSE OF  
DELEGATES

*Tuesday, 4:30 p. m.*

CHAMBER OF COMMERCE BUILDING

Roll Call (*No alternates are to be seated for delegates attending yesterday's meeting*).

Recommendations of reference committees:

- No. 1, Health and Education, W. C. Jones, Jr.  
No. 2, Public Policy, H. A. Walker  
No. 3, Finance, Shaler Richardson

Other unfinished business

Announcements

Adjournment.

COCKTAIL PARTY

*Tuesday, 6:30 p. m.*

TAMPA TERRACE HOTEL

*Dinner Ticket (\$3.00) admits holder to both Cocktail Party and Association Dinner*

ASSOCIATION DINNER

*Tuesday, 7:30 p. m.*

PALM ROOM

*Dinner Tickets (\$3.00) may be obtained at the registration desk.*

SECOND GENERAL SESSION

*Tuesday, 8:30 p. m.*

PALM ROOM

Call to Order, Leigh F. Robinson, President.

Address (by invitation) "Bleeding Lesions of the Gastrointestinal Tract," (lantern slides), B. R. Kirklin, Head of Section on Roentgenology, Mayo Clinic, Rochester.

Awarding of Sports Prizes.

DANCE

*Tuesday, 10 p. m.*

PALM ROOM

WEDNESDAY

FOURTH SCIENTIFIC ASSEMBLY

*Wednesday, 9 to 11:30 a. m.*

PALM ROOM

13. "Experimental Atabrine Therapy in Granuloma Inguinale," (Lantern Slides), Alan Brown, Jacksonville.

The successful treatment of Oriental sore caused by *Leishmania tropica* with atabrine; similarity of this organism to Donovan bodies of granuloma inguinale; belief of some workers that Donovan bodies are protozoans. Experimental therapy of granuloma inguinale with this protozoicide. Atabrine therapy in cases of granuloma inguinale tried by oral, intravenous, topical injection and local application methods. Report of research.

Discussion: Wiley M. Sams, Miami;  
G. C. Bottari, Tampa.

14. "Medicine, Public Health and Local Government," A. B. McCreary, Jacksonville.

Discussion: Gilbert S. Osincup, Orlando;  
M. Jay Flipse, Miami.

15. "Compensation in Industrial Ophthalmology," Nelson M. Black, Miami.

Discussion: Bascom H. Palmer, Miami;  
Shaler Richardson, Jacksonville.

16. "The Role of X-Ray Therapy in Non-Malignant Disease," Alfred G. Levin, Miami.

The indications and contraindications for x-ray therapy in various types of inflammatory processes and other non-neoplastic disease will be considered. The advantage of early treatment of furuncles and carbuncles will be stressed with illustrative case reports. The newer applications of radiation therapy in disorders of the endocrine and nervous systems will be described briefly and the application to disorders of the respiratory, digestive, reproductive and urinary tracts will be mentioned.

Discussion: O. O. Feaster, St. Petersburg;  
H. B. McEuen, Jacksonville.

17. Clinicopathologic Conference. Franz Stewart, Director, Miami; Philipp Rezek, Pathologist, Jackson Memorial Hospital, Miami.

## THIRD GENERAL SESSION

*Wednesday, 12 o'clock*

PALM ROOM

President Robinson in the Chair.  
 Unfinished Business.  
 New Business.  
 Election of President-elect.  
 Election of First Vice-President.  
 Election of Second Vice-President.  
 Election of Third Vice-President.  
 Election of Secretary-Treasurer and Editor of Journal.  
 Dr. J. Sam Turberville escorted to the Chair as new President.  
 Presentation of Past-President's Button to Dr. Leigh F. Robinson by Dr. J. H. Pierpont.  
 Adjournment.

## SPECIAL GROUP MEETINGS

 TWENTY-FIRST ANNUAL MEETING  
 FLORIDA RAILWAY SURGEONS'  
 ASSOCIATION

## OFFICERS

H. D. Clark, President.....Ft. Pierce  
 L. F. Carlton, President-Elect.....Tampa  
 T. H. Bates, Vice-President.....Lake City  
 W. C. Page, Secretary-Treasurer.....Cocoa

## COMMITTEES

*Executive*

V. A. Lockwood, Chairman.....St. Augustine  
 Herman Watson.....Lakeland  
 T. M. McDuffee.....Manatee

*Scientific*

J. W. Alsobrook, Chairman.....Plant City  
 W. P. Adamson.....Tampa  
 J. R. Boling.....Tampa

## STAG DINNER

*Sunday, 7:30 p. m.*

TERRACE LOUNGE DINING ROOM

## GENERAL SESSION

*Monday, 9:30 a. m.*

PALM ROOM

Call to Order, H. D. Clark, President.  
 Invocation.  
 Address of Welcome.  
 Minutes.  
 Reports of Committees.  
 President's Address.

## SCIENTIFIC PROGRAM

J. W. Alsobrook, Presiding

1. "Acute Cholecystitis," Julius C. Davis, Quincy  
 Discussion: Leland F. Carlton, Tampa
2. "The Traumatic Surgeon and His Problem,"  
 A. R. Beyer, Tampa  
 Discussion
3. "Fractures of the Pelvis," T. H. Bates, Lake City  
 Discussion
4. "Fractures of the Neck of the Femur," (Motion  
 Pictures) Fred H. Albee, Venice  
 Discussion: H. D. Van Schaick, Jacksonville

## BUSINESS MEETING

Election of Officers and Induction into Office.  
 Announcements.  
 Adjournment.

FIFTH ANNUAL MEETING  
FLORIDA PEDIATRIC SOCIETY

## OFFICERS

Warren W. Quillian, President.....Coral Gables  
 Ludo von Meysenbug, Vice-President...Daytona Beach  
 George N. Leonard, Secretary.....Miami Beach

*Sunday, April 28*

ROOM 203, TAMPA TERRACE HOTEL

8:00 p. m. Dinner Meeting.  
 "Rheumatic Heart Disease Among Children  
 of Florida," E. Sterling Nichol, Miami,  
 Guest Speaker.

*Monday, April 29*

ROOM 203, TAMPA TERRACE HOTEL

10:00 a.m. Round Table Discussion:  
 "Rheumatic Heart Disease: Occurrence,  
 Clinical Course, Treatment."  
 Leader: George H. Cook, Tampa.  
 Associates: Hillard W. Willis, Miami;  
 E. Jennings Derrick, W. Palm  
 Beach;  
 Thomas M. Palmer, Jackson-  
 ville.

NINTH ANNUAL SPRING MEETING  
FLORIDA RADIOLOGICAL SOCIETY

## OFFICERS

H. B. McEuen, President.....Jacksonville  
 J. H. Lucinian, Vice President.....Miami  
 J. N. Moore, Secretary.....Ocala

*Sunday, April 28*

ROOM 321, TAMPA TERRACE HOTEL

10:00 a. m. Business Meeting.  
 12:30 p. m. Luncheon in Room 321 (75c).  
 1:30 p. m. Round Table discussion and exhibit of films.  
 3:00 p. m. "The Stomach and Duodenum After Opera-  
 tion," B. R. Kirklin, Mayo Clinic, Rochester,  
 Minn.  
 7:00 p. m. Round Table discussion and exhibit of films.

*Monday, April 29*

ROOM 321, TAMPA TERRACE HOTEL

9:00 a. m. Roentgen and Radium Therapy discussion.  
 11:30 a. m. Election of Officers.

REGULAR QUARTERLY MEETING OF THE  
FLORIDA SOCIETY OF DERMATOLOGY  
AND SYPHILOLOGY

## OFFICERS

Alan Brown, President.....Jacksonville  
 Lauren M. Sompayrac, Secretary .....Jacksonville

*Monday, April 29*

ROOM 715, CITIZENS BANK BUILDING

9:00 a. m. Clinical Session, presented by Chadbourne  
 A. Andrews.

*Monday, April 29*

ROOM 310, TAMPA TERRACE HOTEL

12:00 noon Luncheon (75c) and Business Meeting.



SECOND ANNUAL MEETING  
FLORIDA INTERNISTS' SOCIETY

OFFICERS

W. C. Blake, President.....Tampa  
Kenneth Phillips, Secretary.....Miami

*Monday, April 29*

ROOM 207, TAMPA TERRACE HOTEL

10:00 a. m. Scientific Session.

1. "Theories of Renal Function," James A. Bradley, St. Petersburg.  
Discussion.
2. "Case Report—An Unusual Case of Tuberculosis in a Ten Year Old Girl," Douglas D. Martin, Tampa.  
Discussion.
3. "Functional Heart Disease," Norval M. Marr, St. Petersburg.  
Discussion.
4. "Death From Insulin Shock with Autopsy," H. Mason Smith, Tampa.  
Discussion.

Election of Officers.

12:00 noon Luncheon in Room 207 (75c). Introduction of visiting Cuban physicians.

SECOND ANNUAL MEETING FLORIDA  
ASSOCIATION OF INDUSTRIAL SURGEONS

OFFICERS

Harrison A. Walker, President.....Miami Beach  
G. Frederick Oetjen, Treasurer.....Jacksonville  
A. M. Bidwell, Secretary.....Tampa

*Monday, April 29*

ROOM 205, TAMPA TERRACE HOTEL

11:00 a. m. President's Address, Harrison A. Walker, Miami Beach.

11:05 a. m. Address (by invitation) "State Aspect," Honorable Harold C. Wall, Chairman, Florida Industrial Commission, Tallahassee.

11:20 a. m. "National Aspect," Mr. A. G. Parks, Executive Secretary, Industrial Physicians and Surgeons, Chicago.

11:25 a. m. "Longshoremen's Aspect," Mr. Richard P. Lawson, U. S. Deputy Commissioner, Longshoremen's and Harbor Workers' Compensation Commission, Jacksonville.

11:30 a. m. Business meeting and election of officers.

12 noon Round table discussion.

*Tuesday, April 30*

TAMPA TERRACE HOTEL

12:30 p. m. Luncheon, Terrace Lounge Dining Room (75c).

SECOND ANNUAL MEETING  
FLORIDA SOCIETY OF OPHTHALMOLOGY  
AND OTOLARYNGOLOGY

OFFICERS

S. B. Forbes, Temporary Chairman.....Tampa

*Monday, April 29*

ROOM 206, TAMPA TERRACE HOTEL

11:00 a. m. Scientific Session—(*Papers limited to 20 minutes each, no discussion*).

1. "The Devitalized Tooth—A Factor in Ophthalmology," Bascom H. Palmer, Miami.
2. "Retinal Detachment," Shaler Richardson, Jacksonville.
3. "Surgical Treatment of Deafness," M. A. Lischkoff, Pensacola.
4. "Otorhinologic Hygiene of Swimming," (With motion pictures), H. Marshall Taylor, Jacksonville.

12:30 p. m. Luncheon and Business Meeting, Room 206.  
Election of Officers.

HEALTH OFFICERS' SECTION OF THE  
FLORIDA PUBLIC HEALTH ASSOCIATION

OFFICERS

J. S. Spoto, President.....Tampa  
K. K. Waering, Vice President.....Jacksonville  
I. E. Simmons, Secretary.....Quincy

*Monday, April 29*

ROOM 214, TAMPA TERRACE HOTEL

9:00 a. m. "County Health Organization in Florida," Frank V. Chappell, Jacksonville.  
Discussion.

9:50 a. m. "Diplomacy in the Field of County Health Work," W. H. Pickett, St. Petersburg.  
Discussion.

10:30 a. m. "The Laboratory and the Health Officer," J. N. Patterson, Jacksonville.  
Discussion.

11:10 a. m. "The Relationship of the County Health Officer to the Venereal Disease Program," L. J. Hanchett, Jacksonville.  
Discussion.

12:00 noon Announcements.

FOURTEENTH ANNUAL MEETING  
WOMAN'S AUXILIARY

OFFICERS

Mrs. L. C. Ingram, President.....Orlando  
Mrs. Gordon H. Ira, 1st Vice-President.. Jacksonville  
Mrs. F. W. Krueger, 2nd Vice-President.. Jacksonville  
Mrs. John Hatfield, Corresponding Secretary.. Orlando  
Mrs. Leroy H. Oetjen, Sec'y-Treas..... Leesburg  
Mrs. Clayton E. Royce, Historian..... Jacksonville  
Mrs. Edward Jelks, Parliamentarian..... Jacksonville

COMMITTEE CHAIRMEN

Mrs. John A. Pines, Press and Publicity..... Orlando  
Mrs. Leigh F. Robinson, Hygeia..... Ft. Lauderdale  
Mrs. J. E. Maines, Jr., Public Relations... Gainesville  
Mrs. S. M. Copeland, Legislation..... Jacksonville  
Mrs. Gordon H. Ira, Program..... Jacksonville  
Mrs. R. L. Cline, Finance..... Lakeland  
Mrs. J. W. McMurray, Exhibits..... Ft. Lauderdale  
Mrs. Walter A. Weed, Archives..... Lakeland  
Mrs. F. W. Krueger, Organization..... Jacksonville

## LOCAL COMMITTEE CHAIRMEN

|                           |                   |
|---------------------------|-------------------|
| Mrs. W. M. Rowlett.....   | General Chairman  |
| Mrs. H. Mason Smith.....  | Vice-Chairman     |
| Mrs. W. C. Blake.....     | Hospitality       |
| Mrs. George L. Cook.....  | Registration      |
| Mrs. R. Renfro Duke.....  | Flowers           |
| Mrs. E. S. Gilmer.....    | Yacht Club Dinner |
| Mrs. John Boling.....     | Luncheon          |
| Mrs. E. F. Shaver.....    | Transportation    |
| Mrs. Jos. Taylor.....     | Cocktail Party    |
| Mrs. H. Mason Smith.....  | Finance           |
| Mrs. J. C. Dickinson..... | Publicity         |

## PROGRAM

*Monday, April 29*

- 10:30 a.m. Pre-Convention Board Meeting, Room 310, Tampa Terrace Hotel
- 2:00 p.m. Motorcade via Davis Causeway to Clearwater, Gulf Beaches, and St. Petersburg, returning via Gandy Bridge to the Tampa Yacht and Country Club for dinner.
- 6:30 p.m. Cocktail Party followed by dinner at the Tampa Yacht and Country Club.

*Tuesday, April 30*

- 10:00 a.m. General Auxiliary Session, Room 321, Tampa Terrace Hotel.  
Call to Order, Mrs. L. C. Ingram, President.  
Invocation, The Rev. Adiel J. Moncrief, Jr.  
Address of Welcome,  
Mrs. W. M. Rowlett, Tampa.  
Response, Mrs. Clyde Anderson, St. Petersburg.  
Recognition of National President, Mrs. Rollo Packard, Chicago.  
Recognition of Past State Presidents  
Recognition of Chairman of Advisory Committee, Dr. Gordon H. Ira, Jacksonville.  
In Memoriam, Mrs. J. W. McMurray, Ft. Lauderdale.

Reading of Minutes and Treasurer's Report, Mrs. Leroy H. Oetjen, Leesburg.  
Reports:

Credential and Registration Committee, Mrs. Geo. L. Cook, Chairman, Tampa.  
Entertainment Committee, Mrs. W. M. Rowlett, Chairman, Tampa.

Officers  
Standing Committees,  
County Auxiliaries.  
Special Committees.

Unfinished Business.

New Business.

Resolution on Student Loan Fund, Mrs. Geo. C. Tillman, Chairman, Gainesville.

Report of Nominating Committee, Mrs. J. W. Barge, Chairman, Miami.

Election of Officers.

Report of Courtesy Resolution Committee, Mrs. Edward Jelks, Jacksonville.

Presentation of Gavel.

Presentation of President's Pin.

Reading of Minutes.

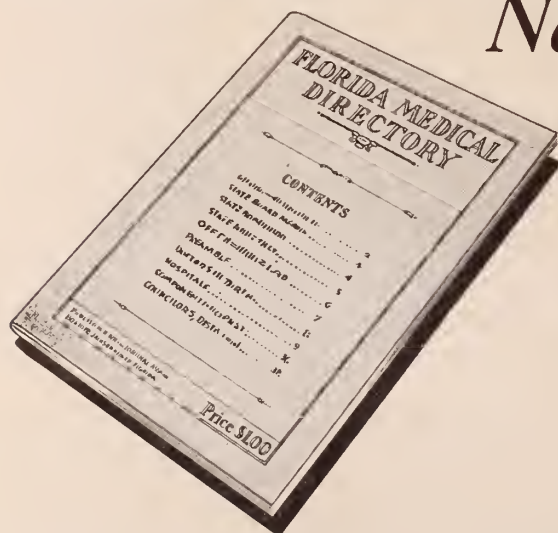
Announcements.

- 1:00 p.m. Luncheon, Columbia Restaurant, 2117 E. Broadway. (Tickets for sale). Guest speaker: Mrs. Rollo Packard, Chicago, President National Auxiliary.  
Post-Convention Board Meeting.

- 6:30 p.m. Cocktail Party at Tampa Terrace Hotel, followed by Association Dinner. (*Dinner Ticket admits holder to both Cocktail Party and Association Dinner*).

*Wednesday, May 1*

- 8:00 a.m. County Auxiliary President's Breakfast, Terrace Lounge Dining Room.  
Golfing will be available for those wishing to play.



## New 1940 DIRECTORY

In still a third section the names and addresses of members of the Florida Medical Association appear.

Learn the value of the book by using it whenever you want facts concerning a physician not well known to you. To what sanitarium can I send a patient? Who is the author of this article in my Journal? Who is the physician who has called me in consultation? Who is the physician anywhere who wants me or whom I want? Is the new doctor practicing in my locality a member of the State Association? Does Doctor So-and-So have a Florida license?

Place your order now.

The Florida Medical Directory is compiled and issued to acquaint its users with the personnel of the medical profession of the State of Florida. It is hoped that the publication will be of such practical value that you will use it daily.

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### FLORIDA MEDICAL ASSOCIATION

P. O. Box 1018

JACKSONVILLE, FLORIDA

Please send me one copy of the third edition of the Florida Medical Directory. Enclosed is One Dollar (\$1.00).

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BYRL RAYMOND KIRKLIN, OUR HONOR GUEST

Dr. Byrl R. Kirklin, guest speaker at the Tampa Convention, has received signal recognition in the field of roentgenology and radiology. After his graduation from the Indiana University School of Medicine and subsequent internship at the Deaconess Hospital, Indianapolis, Doctor Kirklin held the position of resident surgeon and radiologist at the Muncie Home Hospital, Muncie, Indiana, from 1915 to 1917. He then limited his work to roentgenology and practiced this branch of medicine in Muncie from 1917 to 1925, inclusive, with the exception of the period from August, 1917 to February, 1919 during which time he was a First Lieutenant in the Medical Corps, serving as instructor in the Army School of Roentgenology, Fort Riley, Kansas, and as Chief Roentgenologist at the U. S. Army General Hospital, Fort Bayard, New Mexico. In 1922 he was commissioned Major in the Officers' Reserve Corps and is now a Lieutenant Colonel.

Doctor Kirklin came to the Mayo Clinic in May, 1926 as a consultant in the Section on Roentgenology. In January, 1928 he was appointed Director of the Division of Radiology, Mayo Foundation, University of Minnesota Graduate School. Two years later he became head of the Section of Roentgenology of the Mayo Clinic, which position he now holds, in addition to being Professor of Radiology, Mayo Foundation, University of Minnesota Graduate School.

# Florida Medical Association, Inc.

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## NOTICE TO DELEGATES AND COMMITTEE CHAIRMEN

The first meeting of the House of Delegates will be held on Monday at 1:30 p. m. in the Chamber of Commerce Building. Delegates are requested to register as soon after arrival as possible at the registration desk located in the technical exhibit room at the Tampa Terrace Hotel. Delegates arriving late may register at 1:00 p. m. in the Chamber of Commerce Building.

Special badges will be given to those members who are to be seated in the House of Delegates. To be seated in the House, each delegate is required to show his special badge button and present official credentials signed by the secretary of his county medical society. Members and guests who are not delegates are requested to use the section of the room provided for their use in order that official delegates may all sit together, as provided in the By-Laws.

Chairmen of standing committees are urged to be present on time that their reports may be read as scheduled in the official program, which is published in this issue of the Journal. Annual committee reports, resolutions, etc., are to be prepared in duplicate and both copies

laid on the speaker's table immediately after reading.

Delegates and committee chairmen, please note the time, date and place of this first meeting of the House of Delegates—1:30 p. m., Monday, April 29, Chamber of Commerce Building.

## UNITED STATES COURT OF APPEALS REVERSES DECISION OF LOWER COURT

"The United States Court of Appeals on March 4 reversed a district court decision by Justice Proctor that medicine was a 'learned profession' and therefore not within the scope of the Sherman antitrust act," *The Journal of the American Medical Association* for March 9 says. It continues:

As part of its decision, the Court of Appeals said "The fact that defendants are physicians and medical organizations is of no significance." At the heart of the litigation is the question whether the law against restraint of trade applies to the medical profession. The court said: "We think enough has been said to demonstrate that the common law governing restraint of trade has not been confined, as defendants insist, to the field of commercial activity, ordinarily defined as 'trade,' but embraces as well the field of the medical profession." Again the court said: "It cannot be admitted that the medical profession may through its great medical societies, either by rule or disciplinary proceedings, legally effectuate restraints as far reaching as those now charged."

In addition the Court of Appeals held that, while the charge against the American Medical Association may be wholly unwarranted, "For present purposes we must take the charge as though its verity were established; and, in that light, it seems to us clear that the offense is within the condemnation of the statute." The court also said, "It certainly cannot be doubted that Congress intended to exert its full power in the public interest, to set free from unreasonable obstruction the exercise of those rights and privileges which are a part of our constitutional inheritance, and these include immunity from compulsory work at the will of another, the right to choose an occupation, the right to engage in any lawful calling for which one has the requisite capacity, skill, material or capital, and thereafter free enjoyment of the fruits of one's labor."

And it further stated, "Congress undoubtedly legislated on the common law principle that every person has individually, and that the public has collectively, a right to require the course of all legitimate occupations in the District of Columbia to be free from unreasonable obstruction, and likewise in recognition of the fact that all trades, businesses and professions which prevent idleness and exercise men in labor and employment for the benefit of themselves and their families and for the increase of their substance are desirable in the public good and any undue restraint upon them is wrong and is immediate and unreasonable and, therefore, within the purview of the Sherman act."

Further, the court said, "we are mindful of a generally known fact that under these rules and standards (of the medical profession) there has developed an *esprit de corps* largely as a result of which the members of the profession contribute a considerable portion of their time to the relief of the unfortunate and the destitute. All of which may well be acknowledged

to their credit. Notwithstanding these important considerations, it cannot be admitted that the medical profession may, through its great medical societies, either by rule or disciplinary proceedings, legally effectuate restraints as far reaching as those now charged."

Although the attorneys for the American Medical Association have not yet reached a decision as to the next step to be followed, it seems reasonable to believe that they will now go to the United States Supreme Court with a request for a definite decision as to whether or not the practice of medicine comes within the purview of the Sherman antitrust law.

### COURT OF APPEALS RULES AGAINST BRINKLEY

"Last week the United States Fifth Circuit Court of Appeals at New Orleans upheld a federal district court decision in the libel suit brought by John R. Brinkley against the editor of *Hygeia*," *The Journal of the American Medical Association* for March 9 says.

The statement of the court in making this decision was as follows:

We are spared the necessity of discussing the assignments of error in this decision and of reviewing the evidence. It is sufficient to say that the evidence of the plaintiff, placed on the stand by the defendant, tends to show the truth of the statements of fact complained of, and we find no substantial evidence tending to show the defendant was actuated by malice or that plaintiff suffered any actual damage compensable in money.

In the presentation of its case before the federal district court the American Medical Association revealed a long trail of dubious medical activities on the part of Dr. John R. Brinkley for which there was no refutation. In the meantime he continues to broadcast from his station across the Rio Grande, and the United States Post Office continues to permit him the use of the United States mails.

### THE TECHNICAL EXHIBIT

The firms listed below will contribute materially to the success of the convention. They all merit your support.

#### A. S. ALOE COMPANY

The A. S. Aloe Company of St. Louis, Missouri, will exhibit, in booth number 5, a complete line of physicians' equipment. Featured will be the Aloe Steeline furniture, the new Aloe Short Wave unit, and other items of interest to the physician in general practice. The display will be in charge of Aloe representative A. A. Vaughan.

#### BARD-PARKER COMPANY, INC.

Bard-Parker will exhibit the following products at booth No. 2: Rib-Back surgical blades, Renewable Edge scissors, Hematological Case for obtaining blood samples at the bedside, Ortholator for obtaining accurate dental radiographs, Formaldehyde Germicide and Instrument Containers for the rust-proof sterilization of surgical instruments.

#### THE COCA-COLA COMPANY

Coca-Cola will be served to those attending the convention, with the compliments of The Coca-Cola Company.

### CUTTER LABORATORIES

Cutter Laboratories, in booth number 32, will display Dextrose Solutions in Saftiflasks and biological specialties. Of particular interest to visiting physicians will be Sobisminol Mass, the new oral adjuvant in syphilis therapy.

#### EVERHART SURGICAL SUPPLY CO.

The Everhart Surgical Supply Company of Atlanta will have its exhibit in Space 9 at the Tampa meeting. This firm has been serving doctors in Florida for the past twenty-three years, representing Hamilton Furniture, DeForest Diathermy equipment, and other leading well known surgical items. Mr. G. I. Butzer of Orlando is the Florida representative.

#### H. G. FISCHER & CO.

The very latest Fischer Model Short Wave, Shock-proof X-Ray and other apparatus to be exhibited and demonstrated by H. G. Fischer & Co. will interest physicians because of their many unique features of design and performance. The complete Fischer line includes Shockproof X-ray apparatus, short wave units, combination cabinets, galvanic generators, ultra violet and infra-red lamps, many other units, accessories and supplies. Physicians attending the convention are invited to ask for demonstrations of models in which they are interested or to consult with Fischer representative regarding technics made available by Fischer apparatus. Full information on any apparatus sent promptly by mail—on request.

#### C. B. FLEET CO., INC.

Phospho-Soda (Fleet) is a highly concentrated and purified aqueous solution of sodium phosphates. It is non-toxic, rapid but mild in action without irritation of the gastric or intestinal mucosa. Indicated for hepatic dysfunction, and for its thorough eliminating and cleansing action on the upper and lower gut. C. B. Fleet Co., Inc., Lynchburg, Va.

#### FLORIDA CITRUS COMMISSION

The Florida Citrus Commission has a booth at the convention for the first time. Of particular interest is the Commission's new medical book, prepared for physicians, which brings together much of the information found in medical literature on the health qualities of citrus fruits. This book will be distributed at the Commission booth without charge.

#### LEDERLE LABORATORIES, INC.

Lederle Laboratories, Inc., will exhibit in booth number 10 at our annual convention and will greatly appreciate a visit from the physicians attending. You will find on display a complete assortment of Lederle products with ample supply of instructive literature. A representative will be in attendance who will be glad to discuss these products, giving you such information as you may desire.

#### ELI LILLY AND COMPANY

Eli Lilly and Company produced the first commercial preparation of Insulin, contributed to development of liver therapy, and has been responsible for many other therapeutic advancements. Products of importance in routine practice will be displayed.

#### J. B. LIPPINCOTT COMPANY

Among the newer Lippincott publications on display will be the widely acclaimed *Modern Dermatology and Syphilology* by Becker and Obermayer and, of course, the phenomenally successful Thorek's *Modern Surgical Technic*. Other important new works include Dickson and Diveley's *Functional Disorders of the Foot*, Scudder's *Shock*, and Barborka's *Treatment by Diet*. Every physician who has children among his patients will welcome Kugelmass' *Newer Nutrition in Pediatric Practice*.



#### M & R DIETETIC LABORATORIES

M & R Dietetic Laboratories, Inc., Columbus, Ohio, Booth 17, will display Similac and powdered SofKurd. Representatives will be glad to discuss the merit and suggested application of these products.

#### MEAD JOHNSON & COMPANY

Three new Mead products will be on display at Mead Johnson & Company's Booth No. 21: Mead's Nicotinic Acid Tablets, Mead's Thiamin Chloride Tablets, Mead's Ascorbic Acid Tablets. Olac for feeding prematures will also be shown, as well as the complete line of Mead's Infant Diet Materials.

#### THE WM. S. MERRELL COMPANY

The Merrell exhibit, booth No. 8, will show several new therapeutic agents of general interest to physicians. In addition, many other Merrell specialties of established usefulness will be displayed.

#### THE MIAMI SURGICAL COMPANY

The Miami Surgical Company was established in 1926, taken over by B. Marian Beals in 1928, and incorporated in 1937, with Miss Beals as President-Treasurer.

The Miami Surgical Company is a thoroughly ethical firm and distributes all kinds of hospital and physicians' supplies, as well as laboratory equipment.

#### THE C. V. MOSBY COMPANY

Doctors attending the Florida Medical Association convention are cordially invited to visit the Mosby booth, there to inspect the new publications which will be on display. Outstanding new volumes on surgery, allergy, dermatology, operative orthopedics, nervous and mental diseases, heart diseases, x-ray, gynecology and obstetrics, materia medica, and practice of medicine will be shown. Browse through this new material at the Mosby booth, No. 18.

#### NESTLÉ'S MILK PRODUCTS, INC.

Nestlé's Milk Products, Inc., makers of milk products and infant dietary materials for more than 50 years, will feature Lactogen in their exhibit in space No. 22. Physicians interested in infant feeding are cordially invited to visit the Nestlé booth.

#### PARKE, DAVIS & COMPANY

Featured in the Parke-Davis Exhibit will be the sex hormones, Theelin and Theelol; antisypilitic agents, such as Mapharsen and Thio-Bismol; posterior lobe preparations, including Pituitrin, Pitocin and Pitressin; and various adrenalin chloride preparations.

#### PET MILK SALES CORPORATION

An actual working model of a milk condensing plant in miniature will be exhibited by the Pet Milk Company in booths 19 and 20. This exhibit offers an opportunity to obtain information about the production of Irradiated Pet Milk and its uses in infant feeding and general dietary practice. Miniature Pet Milk cans will be given to each physician who visits the Pet Milk booth.

#### PETROLAGAR LABORATORIES

Physicians are cordially invited to visit booth No. 15 where Petrolagar Laboratories, Inc., will be represented by Mr. J. M. Carter. Petrolagar is liquid petrolatum 65 cc. emulsified with 0.4 Gm. agar in a menstruum to make 100 cc., accepted by the Council on Pharmacy and Chemistry of the American Medical Association for the specialized treatment of constipation. Scientific drawings and literature on the subject of constipation will be available in addition to samples of the five types of Petrolagar.

#### PHILIP MORRIS & COMPANY

Philip Morris & Company will demonstrate the method by which it was found that Philip Morris cigarettes, in which diethylene glycol is used as a hygroscopic agent, are less irritating than other cigarettes. Their representatives will be happy to discuss researches on this subject, and problems on the physiological effects of smoking.

#### SHARP & DOHME, INC.

Sharp & Dohme will have their new modern display at Booth 27 this year, featuring their well-known Propadrine Hydrochloride Products. There will also be on display a group of pharmaceutical specialties and biologicals prepared by this house. Capable, well-informed representatives will be on hand to welcome physicians and furnish information on Sharp & Dohme products.

#### SMITH, KLINE & FRENCH LABORATORIES

No registration required. At booth 6, Smith, Kline & French Laboratories, believing that many physicians dislike efforts to make them register, have arranged their booth for self service. Up to date information about Benzedrine Inhaler, Benzedrine Sulfate Tablets, Benzedrine Solution and Pentnucleotide may be obtained in convenient envelopes from literature dispensers. If additional data are desired, the representative will be glad to answer any questions.

#### SOUTHEASTERN OPTICAL CO.

The Southeastern Optical Co., Inc., distributes Ophthalmic Instruments and products of the Bausch and Lomb Optical Co. of Rochester and specializes in Quality Rx work. With offices in Jacksonville, Miami, Miami Beach, St. Petersburg, and Tampa, they are prepared to render twenty-four hour service to any section of Florida.

#### E. R. SQUIBB & SONS

E. R. Squibb & Sons cordially invite physicians attending the Florida Medical Association meeting to visit their exhibit in Booth No. 11. Squibb Vitamin, Glandular, Arsenical and Biological Products and Specialties will be displayed, with special emphasis on the newer chemo-therapeutic agents employed in the treatment of pneumonia and syphilis.

#### STANDARD X-RAY SALES COMPANY OF FLORIDA

The Standard X-Ray Sales Company of Florida represents the Standard X-Ray Company, Chicago, Ill., the largest exclusive manufacturer of x-ray apparatus. Also, a complete line of the better devices for electro-physio-therapeutics is handled. Mr. R. H. Thomas will be in charge of the exhibit booth and extends a cordial invitation to everyone to visit it.

#### THE SURGICAL SUPPLY COMPANY

The Surgical Supply Company, a Florida organization, with stores located in Jacksonville, Tampa, Miami, and Orlando, has an organization of forty, including ten traveling representatives. This Company is entering upon their nineteenth year and they recently moved into their new building in Jacksonville, constructed by Henry L. Parramore, President, expressly for his Company's use. This new building gives the Jacksonville store something like four times the space formerly occupied. Their line of general surgical, laboratory, and hospital supplies and equipment includes many items worthy of special mention. They are distributors of Baxter's and Cutter's Intravenous Solutions; Scanlan Morris pressure sterilizers; Multibeam Operating Lights; Balfour Tables; Burdick and Birtcher Physiotherapy equipment; Beck Lee Hindle Cardiographs; Hamilton professional furniture; genuine Stille Instruments; Lederle Biologicals and Specialties, and many other items. This aggressive organization appreciates the opportunity to serve Florida's medical profession.

## WESTINGHOUSE X-RAY COMPANY

Westinghouse X-Ray Company will exhibit for the first time in the South the new Simplex Unit. This Unit is the latest development in high-powered shock-proof diagnostic equipment. It is economical in its space requirements and economical in price.

## BIRTHS AND DEATHS

## BIRTHS

Dr. and Mrs. Joseph M. Caputo of Lake City announce the birth of a daughter, Nina Maria, on February 27, 1940.

\* \* \*

Dr. and Mrs. Thomas M. Irwin of Orlando announce the birth of a son, Thomas Melbourne, Jr., on March 16, 1940.

\* \* \*

Dr. and Mrs. Donald Scott Fraser of Panama City announce the birth of a son, Howell Barclay, on March 1, 1940.

\* \* \*

Dr. and Mrs. John P. Rowell of St. Petersburg announce the birth of a son on March 17, 1940.

## DEATHS

Dr. Mathew W. Spearman of Lake City died of heart disease on March 1, after an illness of several months. Doctor Spearman had practiced in Lake City for six years.

## STATE NEWS ITEMS

Friends of Dr. W. C. Roberts of Panama City will regret to learn of the death of his father, Dr. W. P. Roberts of Dothan, Ala.

\* \* \*

Dr. Carl S. Lytle of Dunnellon is in Chicago where he is taking a six-weeks' post-graduate course in surgery at the Cook County Graduate School of Medicine. On his return, Doctor Lytle will locate in Ocala.

\* \* \*

Dr. and Mrs. M. A. Lischkoff of Pensacola have returned after spending two weeks in Houston, Texas, and New Orleans. Doctor Lischkoff attended the Postgraduate Assembly while in New Orleans.

\* \* \*

Dr. A. T. Cobb, formerly physician and assistant superintendent of the Florida Farm Colony, announces the opening of offices at 331 W. University Avenue, Gainesville, for the practice of general medicine and surgery.

\* \* \*

Dr. J. E. Maines, Jr., of Gainesville and Dr. W. E. Murphree of Raiford attended the annual Postgraduate Assembly in New Orleans, February 26-29.

A Psychiatric and Mental Hygiene Institute was given at the Florida State Hospital on March 18 and 19, under the sponsorship of a committee of the Florida State League of Nursing Education. The program included the following papers by Florida doctors:

"The Purpose of the Institution" by Dr. R. E. Stevens, Chattahoochee; "Diagnosing Mental Disease" by Dr. W. H. McCullagh, Jacksonville; "Surgery in Mental Patients" by Dr. J. G. Lyerly, Jacksonville; "Manic Depressive Psychoses," Dr. W. D. Rogers, Chattahoochee; and "Hereditary Tendencies of Mental Disease" by Dr. W. G. Miles, Chattahoochee.

Thirty graduate nurses, twelve members of the senior class of the Pensacola Hospital School of Nursing, twenty boys taking abnormal psychology at the University of Florida and twenty-five girls from the Florida State College for Women attended.

\* \* \*

WANTED: Doctor to locate in Carrabelle. Practice extends into Wakulla and Liberty counties. Population of trade area about 3,500; good roads. Collections average around eighty per cent; one doctor at present, two drug stores. Six room brick office free. Write McKissack Drug Store, Carrabelle, Fla.

## COMPONENT COUNTY SOCIETIES

## DADE COUNTY MEDICAL SOCIETY

On the evening of March 5, the Dade County Medical Society held its regular meeting in the Sunshine Room of the Ingraham Building. The scientific program consisted of the following two papers:

"Pyelonephritis—Recent Improvements in Treatment" by James J. Nugent; discussed by Dr. Roy J. Holmes.

"The Management of Pelvic Traumata," Walter Carruthers, Little Rock, Ark.

\* \* \*

## DESOTO-HARDEE-HIGHLANDS-CHARLOTTE-

## GLADES COUNTY MEDICAL SOCIETY

At the meeting of the DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society held in Wauchula on the evening of March 14, it was decided to hold all future meetings of the Society in that city, rather than to rotate the meeting place among several cities as in the past. Dr. W. C. Blake of Tampa was the principal speaker at this meeting.



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Present at this meeting were: Henry P. Bevis, G. F. Highsmith and John A. Simmons of Arcadia; I. W. Chandler and George S. McKnight of Avon Park; E. C. Aurin of Ft. Ogden; Howard V. Weems of Sebring; Miles A. Collier, M. C. Kayton and A. A. Poucher of Wauchula; and W. C. Blake and Robert G. Nelson of Tampa.

\* \* \*

#### DUVAL COUNTY MEDICAL SOCIETY

Dr. Louie Limbaugh was principal speaker at the meeting of the Duval County Medical Society held at the Library of the State Board of Health building on the evening of March 5. His subject was "Some Considerations of Indirect Trauma in Coronary Occlusion," which was discussed by Dr. T. Z. Cason. A business meeting followed the scientific session, after which refreshments were served.

\* \* \*

#### MANATEE COUNTY MEDICAL SOCIETY

With the payment of the last of its assessment, the Manatee County Medical Society has become the seventh component unit to join the honor roll of 100 per cent paid societies. This society, with a membership of 14, is headed by: M. M. Harrison, president; W. D. Sugg, vice-president; and W. E. Wentzel, secretary-treasurer.

\* \* \*

#### PALM BEACH COUNTY MEDICAL SOCIETY

Dr. Frank H. Lahey of the Lahey Clinic, Boston, spoke at a meeting of the Palm Beach County Medical Society held on the evening of February 26 at the George Washington Hotel, West Palm Beach.

Dr. J. H. Pittman, society president, presided at this dinner meeting and a short business session followed.

\* \* \*

#### PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Dr. George A. Dame of Inverness was host at a meeting of the Pasco-Hernando-Citrus County Medical Society held on March 14. Dinner was served at the Jones Cafe, followed by a scientific meeting in Doctor Dame's office. Minutes of the last meeting were read and adopted. Interesting case reports were given by those who attended. Doctor W. Wardlaw Jones invited the society to hold

its next meeting with him at Dade City on April 11.

Attending the meeting were: George R. Creekmore and S. C. Harvard of Brooksville; Edwin H. Brown and W. Wardlaw Jones of Dade City; Claude L. Carter and George A. Dame of Inverness; William H. Walters of Lacoochee; and J. T. Bradshaw of San Antonio.

\* \* \*

#### PINELLAS COUNTY MEDICAL SOCIETY

Dr. Temple Fay, Professor of Neurology and Neurosurgery of Temple University was guest of honor and principal speaker of the Pinellas County Medical Society at a called meeting held at the Shrine Club in St. Petersburg on the evening of February 16. Nurses of the city were invited to hear Doctor Fay.

At the March 1 meeting of the Society, Dr. Clark D. Brooks of Detroit was guest speaker, presenting a paper on "The Diagnosis and Treatment of Surgical Diseases of the Colon."

The Pinellas County Medical Society holds a special place of honor at the present time as it is the largest society in the Association to report 100 per cent of dues paid for 1940. A great deal of credit for this achievement must go to the officers: John A. Herring, president; N. W. Gable, Jr., president-elect; M. A. Nickle and H. D. Solomon, vice-presidents; and to W. C. McConnell who has for a number of years served as secretary and treasurer.

\* \* \*

#### POLK COUNTY MEDICAL SOCIETY

At the February meeting of the Polk County Medical Society, held in Lakeland, the members of the Society again went on record as favoring a county health unit. Mr. Burdette Loomis of Pierce, president of the Polk County Tuberculosis and Health Association, was present and spoke of the work of that organization.

\* \* \*

#### SEMINOLE COUNTY MEDICAL SOCIETY

The Seminole County Medical Society, with a membership of 12, is 100 per cent paid for 1940. This group is headed by Wade H. Garner, president; G. S. Selman, vice-president; and Douglas G. Scott, secretary-treasurer. Congratulations, Seminole County Medical Society.





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\*"Treatment of Acute Anterior Urethritis with Silver Picrate," Knight and Shelanski, AMERICAN JOURNAL  
OF SYPHILIS, GONORRHEA AND VENEREAL DISEASES, Vol. 23, No. 2, pages 201-206, March, 1939.

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## WOMAN'S AUXILIARY

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MRS. GORDON H. IRA, First Vice President....Jacksonville  
MRS. F. W. KRUEGER, Second Vice President ..Jacksonville  
MRS. JOHN HATFIELD, Corresponding Secretary..Orlando  
MRS. HENRY LEROY ORTJEN, Secretary-Treasurer..Leesburg  
MRS. CLAYTON E. ROYCE, Historian.....Jacksonville  
MRS. EDWARD JELKS, Parliamentarian .....Jacksonville

### COMMITTEE CHAIRMEN

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MRS. LEIGH F. ROBINSON, Hygeia.....Ft. Lauderdale  
MRS. ROBERT D. FERGUSON, Public Relations.....Ocala  
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MRS. J. W. McMURRAY, Exhibits.....Ft. Lauderdale  
MRS. WALTER A. WEED, Archives.....Lakeland  
MRS. F. W. KRUEGER, Organization.....Jacksonville

### DISTRICT CHAIRMEN

MRS. G. C. TILLMAN, North Central "B" .....Gainesville  
MRS. E. W. VEAL, Northeast "C" .....Jacksonville  
MRS. W. W. HARDEN, Southwest "D" .....St. Petersburg  
MRS. FRANK D. GRAY, South Central "E" .....Orlando  
MRS. H. A. LEAVITT, Southeast "F" .....Miami

## PRESIDENT'S LETTER

Dear Co-workers:

How fast this year has passed! Some of our dreams have come true and some have not. We have tried to follow the objective of the year and I believe we show that we have hewn to the line.

In visiting the county auxiliaries I have been encouraged by the fine spirit of cooperation. We, who are in the work, know that it is a wonderful work, especially when we go into it wholeheartedly.

If you go down to the stream for water and take a cup you get a cupful, if you take a bucket you can get a bucketful; and so it is in this splendid organization—you get out what you put in.

Recently, I visited the Dade, Broward and Pinellas County Auxiliaries. They are all doing creditable work. Their doctor husbands and their localities should be proud of them. The Dade and Broward County Auxiliaries take complete charge of the Tuberculosis Seal sales and the Pinellas County Auxiliary is doing a splendid work with the Y. W. C. A.

Our Student Loan Fund idea seems to meet with a popular vote. Let us hope that next year we can help a worthy doctor's son or daughter.

Holding the District Auxiliary meetings at the same time and place as the District Medical meetings has, I feel, been beneficial to the work of the President and the state or-

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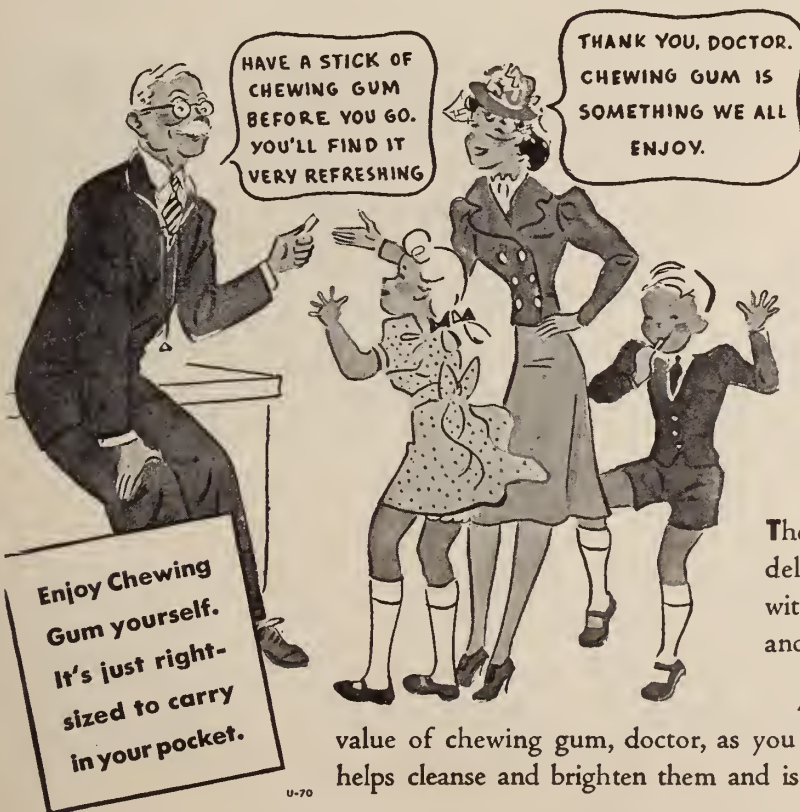
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ganization. Visiting five out of six, personal contacts were made with the women in the various places which has helped to promote the work and create new interest to the extent, I believe, that will eventuate into several new County Auxiliaries.

The two District Auxiliaries, South Central (E) and Southeast (F) that were organized last fall are going forward in their work and are planning for larger meetings this fall when their respective Medical Societies meet.

And, as I am preparing this farewell note, a letter has come to my desk from the Suwannee River Medical Auxiliary, telling of their new organization and how enthusiastic they are in their new work. Some few weeks ago, Mrs. John Hatfield and I with Mrs. George C. Tillman of Gainesville, Mrs. F. W. Krueger and Mrs. Gordon H. Ira of Jacksonville were guests of these ladies at a luncheon meeting held in the Blanche Hotel, Lake City.

Now, we love our state, so let us make our Auxiliary one of the best! Let us have a national pride, so when Dear Old Florida is called out, we may be proud of her standing. And why not? Our men and women are the best in the world.

Again, may I say that you have all given me splendid cooperation.

Good-bye until I see you in Tampa. Remember the dates? Apr. 29, 10:30 a. m., Pre-convention Board Meeting; Apr. 30, 10:00-12:00 Auxiliary Meeting followed by a 1:00 o'clock luncheon, Mrs. Rollo Packard, National Auxiliary President, guest speaker.

Carolyn F. Ingram

President of State Auxiliary.

## COUNTY AUXILIARIES

### DUVAL COUNTY AUXILIARY

The regular meeting of the Woman's Auxiliary to the Duval County Medical Society was held on Thursday afternoon, March 7, at the home of Mrs. H. Marshall Taylor, 3015 St. Johns Avenue with Miss Margaret Taylor and Mrs. J. D. Ferrara, assisting.

Mrs. C. E. Royce, president, presented the social chairman, Mrs. S. R. Norris, who introduced the guest speaker, T. E. Middlebrooks, district supervisor from the United States Bureau of Narcotics, Washington, D. C. His subject, "The Narcotic Problem" was both interesting and educational. Mr. Middle-



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brooks attributed much of the crime of the past to narcotic addicts and said that babies used to form the drug habit about as often as adults because parents gave them paragoric and similar drugs to make them sleep. He stated, however, that narcotics are becoming less of a problem each year, according to information from the United States Bureau of Narcotics in Washington, which has received national recognition for the splendid work it is doing in reducing the number of addicts in recent years. He reported 25 cases in Jacksonville that have been cured.

Interesting reports from the various committees showed an increase in the activities and achievements of the organization during the year. Mrs. Raymond King, Hygeia Chairman, announced that Duval County won the third prize of \$10.00 in the recent Hygeia contest sponsored by the National Organization. Such an honor reflects credit to our state.

Mrs. E. W. Veal gave a brief explanation of the Wagner Bill and urged members to register and vote.

Mrs. S. R. Norris gave a brief report on the Basic Science Law and said that in order to uphold the highest standards of medicine it would be necessary to continue the Basic Science Law in Florida.

Delegates appointed to attend the State Convention in Tampa were Mrs. S. M. Copeland and Mrs. Victor A. Hughes; alternates, Mrs. S. R. Norris and Mrs. Edward Jelks.

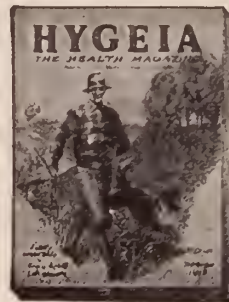
A hobby show of outstanding interest climaxed the meeting. Presented by Mrs. C. R. Wilcox were old prints of rare design and beauty. Mrs. William Kirk showed old glass of antique shape and color; Mrs. J. D. Ferrara, miniature toys of wood and china; Mrs. Frederick J. Waas, a large collection of miniature flower arrangements of distinctive design, color and shape.

Delicious refreshments were served by the hostess committee during the social hour, after which Mrs. Taylor invited members and guests to stroll through her lovely gardens and visit her log cabin of quaint design and historic background, which had been her favorite hobby for years. Seeing this log cabin was like visting a museum of unusual collections from all over the world.

About 40 members and guests were present.

#### MARION COUNTY AUXILIARY

The regular monthly meeting of the Marion County Medical Auxiliary was held March 21, at the Candle-Glo Tea Room for luncheon and the election of officers. Those elected for 1940 are as follows: president, Mrs. C. S. Lytle succeeding Mrs. R. C. Cumming; vice-president, Mrs. J. N. Moore succeeding Mrs. C. S. Lytle; secretary and social chairman, Mrs. H. L. Harrell succeeding Mrs. T. H. Wallis; re-elected treasurer, Mrs. E. G. Lindner.



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**MEDICINE**—Two Weeks' Intensive Course starting June 3rd. Two Weeks' Course Gastro-Enterology starting June 17th. Two Weeks' Course Electrocardiography and Heart Disease, August 5th.

**FRACTURES & TRAUMATIC SURGERY**—Ten Day Intensive Course starting April 22, 1940. Informal Course every week.

**GYNECOLOGY**—Two Weeks' Course June 17, 1940. One Week Personal Course Vaginal Approach to Pelvic Surgery April 8, 1940.

**OBSTETRICS**—Two Weeks' Course June 3, 1940. Informal Course every week.

**OTOLARYNGOLOGY**—Two Weeks' Course starting April 8, 1940. Informal Course every week.

**OPHTHALMOLOGY**—Two Weeks' Course starting April 22, 1940. Informal Course every week. **CYSTOSCOPY**—Ten Day Practical Course rotary every two weeks. One Month and Two Weeks' Courses in Urology every two weeks.

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## COMPONENT SOCIETIES BY DISTRICTS — FLORIDA MEDICAL ASSOCIATION

| Districts                                                | COUNTY SOCIETIES                         | PRESIDENT                                                           | SECRETARY                                                          | MEETING DATE                                                           | COUNCILOR and Counties Not Included in First Column | Members |      |
|----------------------------------------------------------|------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------|---------|------|
|                                                          |                                          |                                                                     |                                                                    |                                                                        |                                                     | Total   | Paid |
| Northwest District (A)<br>Pensacola<br>Oct. 9, 1940      | Bay                                      | Amsie H. Lisenby, M.D.<br>Panama City                               | William C. Roberts, M.D.<br>Panama City                            |                                                                        | A-1-'40<br>Carol C. Webb, M.D.<br>Pensacola         | 10      | 7    |
|                                                          | Escambia                                 | Sidney G. Kennedy, M.D.<br>511 American Nat. Bk. Bldg.<br>Pensacola | W. E. Tugwell, M.D.<br>Box 860<br>Pensacola                        | 2nd Tuesday<br>8:00 P. M.                                              |                                                     | 43      |      |
|                                                          | Walton-Okaloosa                          | A. G. Williams, M.D.<br>Lakewood                                    | R. B. Spires, M.D.<br>DeFuniak Springs                             | 3rd Thursday<br>8:00 P. M.                                             |                                                     | 6       | 100% |
|                                                          | Washington-Holmes                        | R. H. Segrest, M.D.<br>Bonifay                                      | L. H. Paul, M.D.<br>Bonifay                                        |                                                                        | Santa Rosa                                          | 8       | 4    |
|                                                          | Franklin-Gulf                            | Thos. Meriwether, M.D.<br>Wewahitchka                               | J. R. Norton, M.D.<br>Port St. Joe                                 | 3rd Thursday                                                           | A-2-'41<br>B. A. Wilkinson, M.D.<br>Tallahassee     | 6       | 100% |
|                                                          | Jackson                                  | W. R. Wandek, M.D.<br>Marianna                                      | R. N. Joyner, M.D.<br>Marianna                                     | 2nd Tuesday<br>7:30 P. M.                                              |                                                     | 12      | 8    |
|                                                          | Leon-Gadsden-Liberty-Wakulla-Jefferson   | Francis T. Holland, M.D.<br>208 Midyette-Moor Bldg.<br>Tallahassee  | B. A. Wilkinson, M.D.<br>Telephone Bldg.<br>Tallahassee            | Quarterly<br>3:00 P. M.                                                | Calhoun                                             | 38      | 31   |
| North Central District (B)<br>Lake City<br>Oct. 4, 1940  | Columbia                                 | L. J. Arnold, Jr., M.D.<br>Lake City                                | Harry S. Howell, M.D.<br>Blanche Hotel Annex<br>Lake City          | 1st Monday<br>7:30 P. M.                                               | B-3-'41<br>W. S. Nichols, M.D.<br>Lake City         | 20      | 9    |
|                                                          | Madison                                  | E. Long, M.D.<br>Madison                                            | A. F. Harrison, M.D.<br>Madison                                    |                                                                        |                                                     | 3       | 1    |
|                                                          | Taylor                                   | Geo. H. Warren, M.D.<br>Perry                                       | Ralph J. Greene, M.D.<br>Perry                                     | Last Friday<br>8:00 P. M.                                              | Baker-Dixie-Hamilton-Lafayette-Suwannee             | 7       | 6    |
|                                                          | Alachua                                  | Edwin H. Andrews, M.D.<br>134 N. Pleasant St.<br>Gainesville        | J. Maxey Dell, Jr., M.D.<br>333 W. Main St., S.<br>Gainesville     | 2nd Wednesday<br>7:30 P. M.                                            | B-4-'40<br>James L. Strange, M.D.<br>McIntosh       | 30      | 21   |
|                                                          | Marion                                   | Henry C. Dozier, M.D.<br>9 No. Magnolia St.<br>Ocala                | R. C. Cumming, M.D.<br>Commercial Bank Bldg.<br>Ocala              | 3rd Thursday<br>12:30 P. M.                                            |                                                     | 24      | 100% |
|                                                          | Pasco-Hernando-Citrus                    | Wm. H. Walters, Jr., M.D.<br>Lacoochee                              | G. R. Creekmore, M.D.<br>Brooksville                               | 2nd Thursday<br>7:00 P. M.                                             |                                                     | 15      | 10   |
|                                                          | Sumter                                   |                                                                     |                                                                    |                                                                        | Bradford-Gilchrist-Levy-Union                       | 2       |      |
| N. E. District (C)<br>Daytona Beach<br>Oct. 3, 1940      | Duval                                    | Chas. B. Mabry, M.D.<br>439 St. James Bldg.<br>Jacksonville         | Lauren M. Sompayrac, M.D.<br>459 St. James Bldg.<br>Jacksonville   | 1st Tuesday<br>8:15 P. M.                                              | C-5-'41<br>R. B. McIver, M.D.<br>Jacksonville       | 179     | 134  |
|                                                          | St. Johns                                | Donald T. Rankin, M.D.<br>East Coast Hospital<br>St. Augustine      | Vernon A. Lockwood, M.D.<br>East Coast Hospital<br>St. Augustine   | 3rd Tuesday<br>8:30 P. M.                                              | Clay-Nassau                                         | 10      | 9    |
|                                                          | Putnam                                   | G. M. Zeagler, M.D.<br>Glendale Hospital<br>Palatka                 | Bernard E. Kane, M.D.<br>Crescent City                             | 2nd Tuesday in<br>Feb., April, June,<br>Aug., Oct., Dec.<br>7:00 P. M. | C-6-'40<br>George M. Green, M.D.<br>Daytona Beach   | 11      | 6    |
|                                                          | Volusia                                  | L. V. L. Brown, M.D.<br>DeLand                                      | R. L. Miller, M.D.<br>258 1/2 S. Beach St.<br>Daytona Beach        | 2nd Tuesday<br>7:30 P. M.                                              | Flagler                                             | 42      | 35   |
| Southwest District (D)<br>Tallahassee<br>Oct. 31, 1940   | Hillsborough                             | John R. Boling, M.D.<br>1207 First Nat. Bk. Bldg.<br>Tampa          | James S. Grabie, M.D.<br>811 Citizens Bank Bldg.<br>Tampa          | 1st Tuesday<br>8:00 P. M.                                              | D-7-'41<br>W. C. McConnell, M.D.<br>St. Petersburg  | 110     | 85   |
|                                                          | Manatee                                  | M. M. Harrison, M.D.<br>Professional Bldg.<br>Bradenton             | W. E. Wentzel, M.D.<br>Box 245<br>Bradenton                        | 3rd Tuesday<br>7:00 P. M.                                              |                                                     | 14      | 100% |
|                                                          | Pinellas                                 | John A. Herring, M.D.<br>259 Third St., No.<br>St. Petersburg       | W. C. McConnell, M.D.<br>313 First Federal Bldg.<br>St. Petersburg | 1st and 3rd Fridays<br>6:30 P. M.                                      |                                                     | 105     | 100% |
|                                                          | Sarasota                                 | Millard B. White, M.D.<br>151 S. Pineapple Ave.<br>Sarasota         | Stanley T. Martin, M.D.<br>Sarasota                                | 2nd Tuesday<br>8:30 P. M.                                              |                                                     | 15      | 3    |
|                                                          | DeSoto-Hardee-Highlands-Charlotte-Glades | Hartley E. Boorum, M.D.<br>37-38 S. Ridgewood Drive<br>Sebring      | Howard V. Weems, M.D.<br>22 Oak St.<br>Sebring                     | 2nd Tuesday<br>8:00 P. M.                                              | D-8-'40<br>Herman Watson, M.D.<br>Lakeland          | 20      | 19   |
|                                                          | Lee                                      | A. S. Byle, M.D.<br>311 2nd St.<br>Fort Myers                       | Fred D. Bartleson, M.D.<br>Fort Myers                              | 3rd Friday<br>7:30 P. M.                                               |                                                     | 14      | 100% |
|                                                          | Polk                                     | Henry Fuller, M.D.<br>Mulberry                                      | Jere W. Annis, M.D.<br>Box 1021<br>Lakeland                        | 2nd Wednesday<br>1:00 P. M.                                            | Collier-Hendry                                      | 63      | 47   |
| South Central District (E)<br>Palm Beach<br>Nov. 1, 1940 | Brevard                                  | I. M. Hay, M.D.<br>Melbourne                                        | I. K. Hicks, M.D.<br>Melbourne                                     | 3rd Tuesday                                                            | E-9-'40<br>W. C. Page, M.D.<br>Cocoa                | 10      | 9    |
|                                                          | Lake                                     | W. L. Ashton, M.D.<br>Umatilla                                      | Oliver Emerson, M.D.<br>Tavares                                    | 1st Thursday<br>12:30 P. M.                                            |                                                     | 18      | 11   |
|                                                          | Orange                                   | Chas. J. Collins, M.D.<br>209 Exchange Bldg.<br>Orlando             | Fred Mathers, M.D.<br>Box 53<br>Orlando                            | 3rd Wednesday<br>8:30 P. M.                                            |                                                     | 81      | 79   |
|                                                          | Seminole                                 | Wade H. Garner, M.D.<br>Sanford                                     | Douglas G. Scott, M.D.<br>212 N. Park Ave.<br>Sanford              | 2nd Monday<br>7:00 P. M.                                               | Osceola                                             | 12      | 100% |
|                                                          | St. Lucie-Okeechobee-Indian River-Martin | Francis A. Gowdy, M.D.<br>Ft. Pierce                                | Adrian M. Sample, M.D.<br>Ft. Pierce                               | 3rd Thursday<br>8:00 P. M.                                             | E-10-'41<br>A. M. Sample, M.D.<br>Ft. Pierce        | 18      | 16   |
| S. E. District (F)<br>Key West<br>Nov. 2, 1940           | Broward                                  | L. B. Elliston, M.D.<br>314 Sweet Bldg.<br>Ft. Lauderdale           | E. C. Chamberlain, M.D.<br>120 Sweet Bldg.<br>Fort Lauderdale      | 4th Wednesday<br>8:00 P. M.                                            | F-11-'40<br>Lloyd J. Netto, M.D.<br>West Palm Beach | 38      | 37   |
|                                                          | Palm Beach                               | James H. Pittman, M.D.<br>Box 602<br>W. Palm Beach                  | C. Jennings Derrick, M.D.<br>Box 574<br>W. Palm Beach              | 4th Monday<br>8:00 P. M.                                               |                                                     | 64      | 51   |
|                                                          | Dade                                     | Joseph S. Stewart, M.D.<br>525 duPont Bldg.<br>Miami                | Franz Stewart, M.D.<br>525 duPont Bldg.<br>Miami                   | 1st Tuesday<br>8:30 P. M.                                              | F-12-'41<br>Kenneth Phillips, M.D.<br>Miami         | 311     | 203  |
|                                                          | Monroe                                   | Harry C. Galey, M.D.<br>532 Fleming St.<br>Key West                 | W. R. Warren, M.D.<br>511 Eaton St.<br>Key West                    | 1st Sunday<br>9:00 P. M.                                               |                                                     | 5       | 100% |



STATE AND SECTIONAL MEETINGS

| SOCIETY                             | PRESIDENT                           | SECRETARY                           | ANNUAL MEETING                   |
|-------------------------------------|-------------------------------------|-------------------------------------|----------------------------------|
| Florida Medical Association.....    | Leigh F. Robinson, Ft. Lauderdale   | Shaler Richardson, Jacksonville...  | Tampa, Apr. 29, 30 & May 1, 1940 |
| Florida Medical Districts:          |                                     |                                     |                                  |
| —Northwest .....                    | B. A. Wilkinson, Tallahassee .....  | Stewart Thompson, Jacksonville...   | Pensacola, Oct. 5, 1940          |
| —North Central .....                | William S. Nichols, Lake City ..... | " " "                               | Lake City, Oct. 4, 1940          |
| —Northeast .....                    | Robt. B. McIver, Jacksonville.....  | " " "                               | Daytona Beach, Oct. 3, 1940      |
| —Southwest .....                    | W. C. McConnell, St. Petersburg...  | " " "                               | Dunedin, Oct. 31, 1940           |
| —South Central .....                | A. M. Sample, Ft. Pierce.....       | " " "                               | Ft. Pierce, Nov. 1, 1940         |
| —Southeast .....                    | Kenneth Phillips, Miami.....        | " " "                               | Key West, Nov. 2, 1940           |
| Tampa Medical Association.....      | M. S. Davie, Dothan.....            | D. L. Cannon, Montgomery.....       | Birmingham, April 16-18, 1940    |
| Georgia Medical Assn. of.....       | W. H. Myers, Savannah.....          | E. D. Shanks, Atlanta.....          | Savannah, April 23-26, 1940      |
| Florida—                            |                                     |                                     |                                  |
| State Dental Association.....       | E. B. Penn, Miami.....              | E. C. Lunsford, Miami.....          | St. Petersburg, Nov., 1940       |
| Soc. of Derm. and Syph.....         | Alan Brown, Jacksonville.....       | Lauren M. Sompayrac, Jacksonville   | Tampa, April 29, 1940            |
| East Coast Medical Association..... | I. M. Hay, Melbourne.....           | J. S. Stewart, Miami.....           | Miami, 1940                      |
| State Hospital Association.....     | J. H. Therrell, Chattahoochee.....  | Mr. Fred M. Walker, Jacksonville... | Mississippi, March, 1940         |
| Assn. of Industrial Surgeons.....   | Harrison A. Walker, Miami Beach...  | A. M. Bidwell, Tampa.....           | Tampa, Apr. 29, 1940             |
| Internists' Society.....            | W. C. Blake, Tampa.....             | Kenneth Phillips, Miami.....        | Tampa, Apr. 29, 1940             |
| Medical Postgraduate Course.....    | Turner Z. Cason, Jacksonville.....  | Chairman                            | Jacksonville, June 24-29, 1940   |
| Soc. of Ophthal. & Otol.....        | S. B. Forbes, Tampa.....            | Temporary Chairman.....             | Tampa, Apr. 29, 1940             |
| State Nurses Association.....       | Mrs. M. Stetson, St. Petersburg     | Mrs. Phyllis Leonard, St. Augustine |                                  |
| Pediatric Society.....              | Warren W. Quillian, Coral Gables    | G. N. Leonard, Miami Beach.....     | Tampa, Apr. 28, 29, 1940         |
| Pharmaceutical Association.....     | Mr. S. F. Harris, Jacksonville..... | Mr. A. W. Morrison, Miami.....      | Tampa, May, 1940                 |
| Public Health Association.....      | A. B. McCreary, Jacksonville.....   | E. M. L'Engle, Jacksonville.....    | Tampa, Dec., 1940                |
| Radiological Society.....           | H. B. McEuen, Jacksonville.....     | J. N. Moore, Ocala.....             | Tampa, Apr. 29, 1940             |
| Railway Surgeons' Association.....  | H. D. Clark, Ft. Pierce.....        | W. C. Page, Cocoa.....              | Tampa, Apr. 28, 1940             |
| Tuberculosis & Health Assn.....     | Mr. G. E. Therry, W. Palm Beach...  | Mrs. May Pyncheon, Jacksonville...  | Spring, 1940                     |
| Chattahoochee Valley Med. Assn..... | M. Y. Dabney, Birmingham.....       | Frank K. Boland, Atlanta.....       | Albany, Ga., July 9-11, 1940     |
| East Coast Clinical Society.....    | J. H. Dodson, Mobile.....           | C. C. Rouse, Mobile.....            |                                  |
| Eastern Derm. Assn.....             | Jack Jones, Atlanta.....            | Howard Hailey, Atlanta.....         | Atlanta, Ga., Sept. 1, 1940      |
| Eastern Surgical Congress.....      | R. L. Sanders, Memphis.....         | B. T. Beasley, Atlanta.....         | Birmingham, Mar. 11-13, 1940     |
| Western Medical Association.....    | Arthur T. McCormack, Louisville...  | Mr. C. P. Loran, Birmingham.....    | Louisville, Ky., Nov., 1940      |
| Savannah River Medical Society..... | T. H. Bates, Lake City.....         | H. S. Howell, Lake City.....        |                                  |

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of the

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### NEXT SESSIONS

American Medical Association, New York, June 10-14, 1940  
Florida Medical Association, Jacksonville, 1941  
Southern Medical Association, Louisville, Ky., November 12-15, 1940



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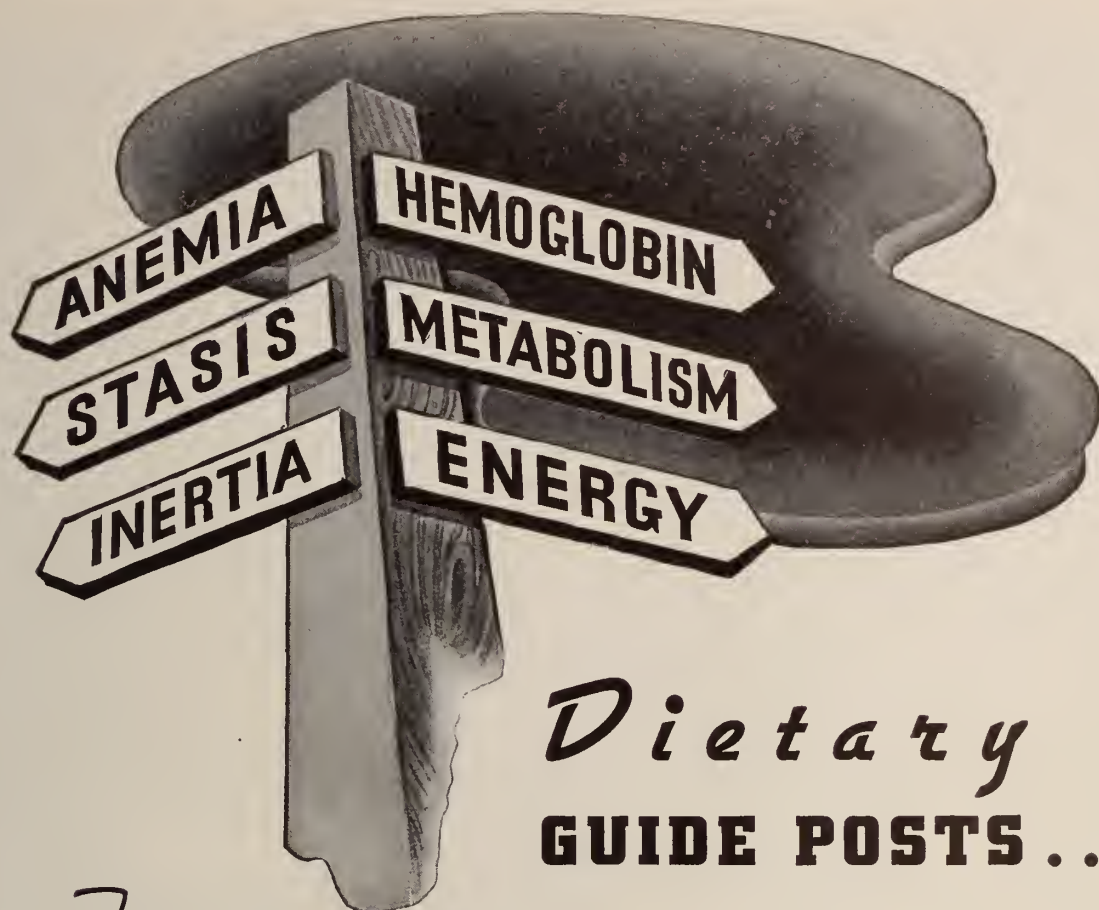


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\* Medical Record—149:63:1939

\*\* Archives of Pediatrics—Nov. 1939

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*Laryngoscope, Feb. 1935  
Vol. XLV, No. 2, 149-154*

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Guttmann, E. and Sargent, W.: Observations on Benzedrine—Brit. Med. J., 1:1013, May 15, 1937.

Nathanson, M. H.: The Central Action of Beta-aminopropylbenzene (Benzedrine)—J.A.M.A., 108:528, Feb. 13, 1937.

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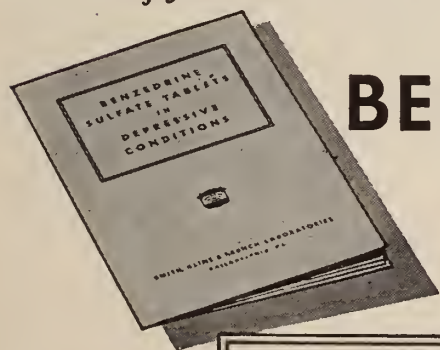
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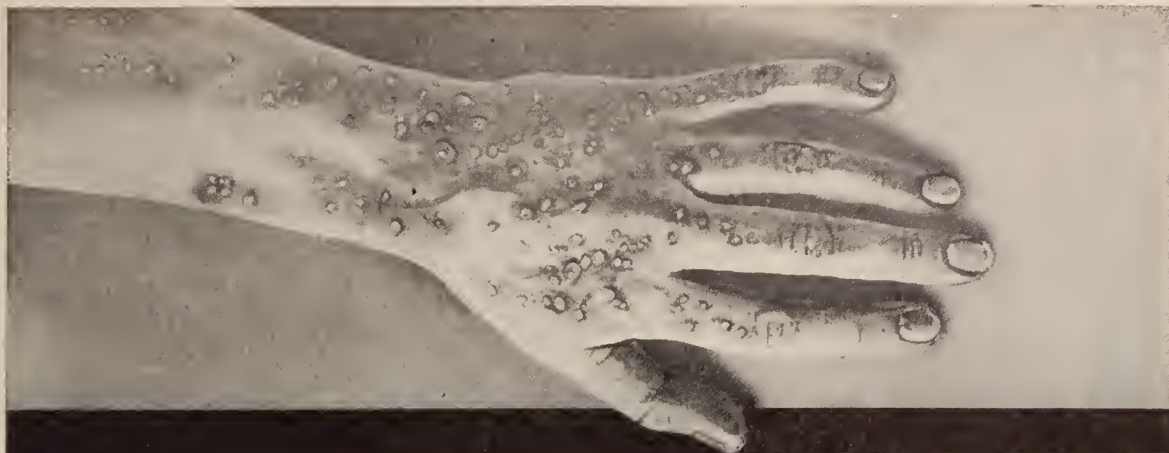
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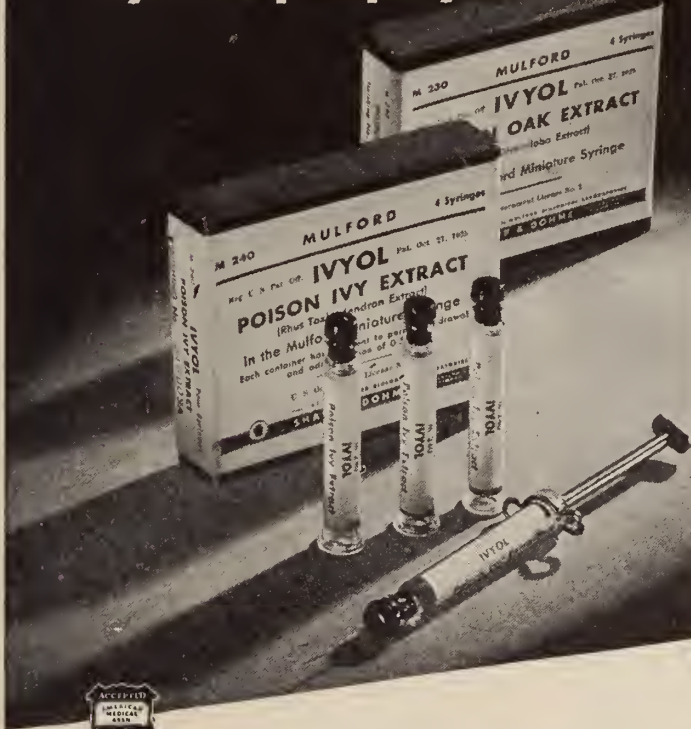
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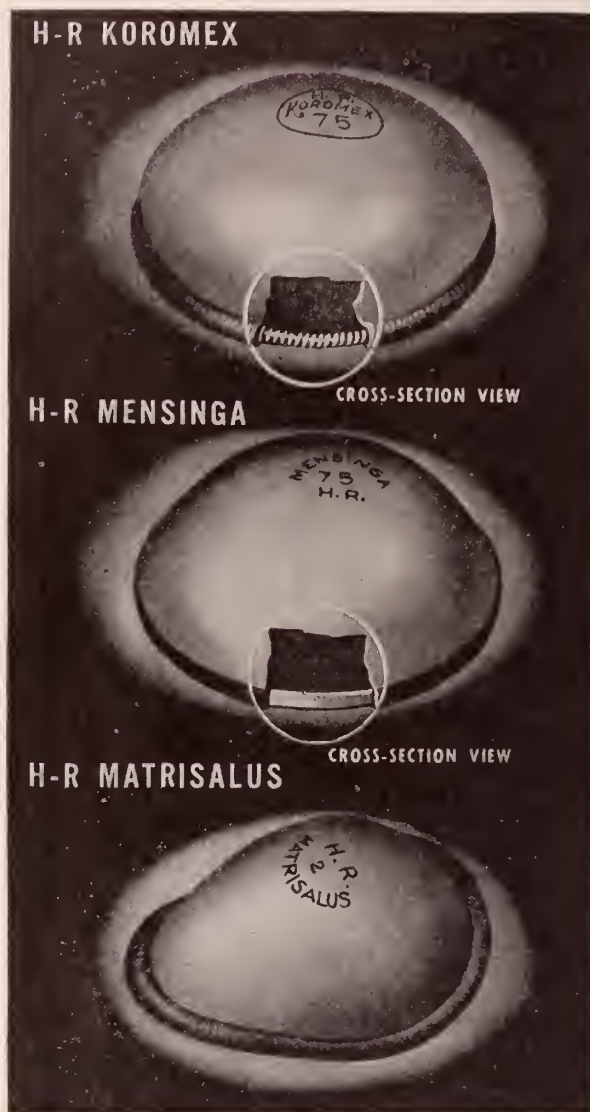
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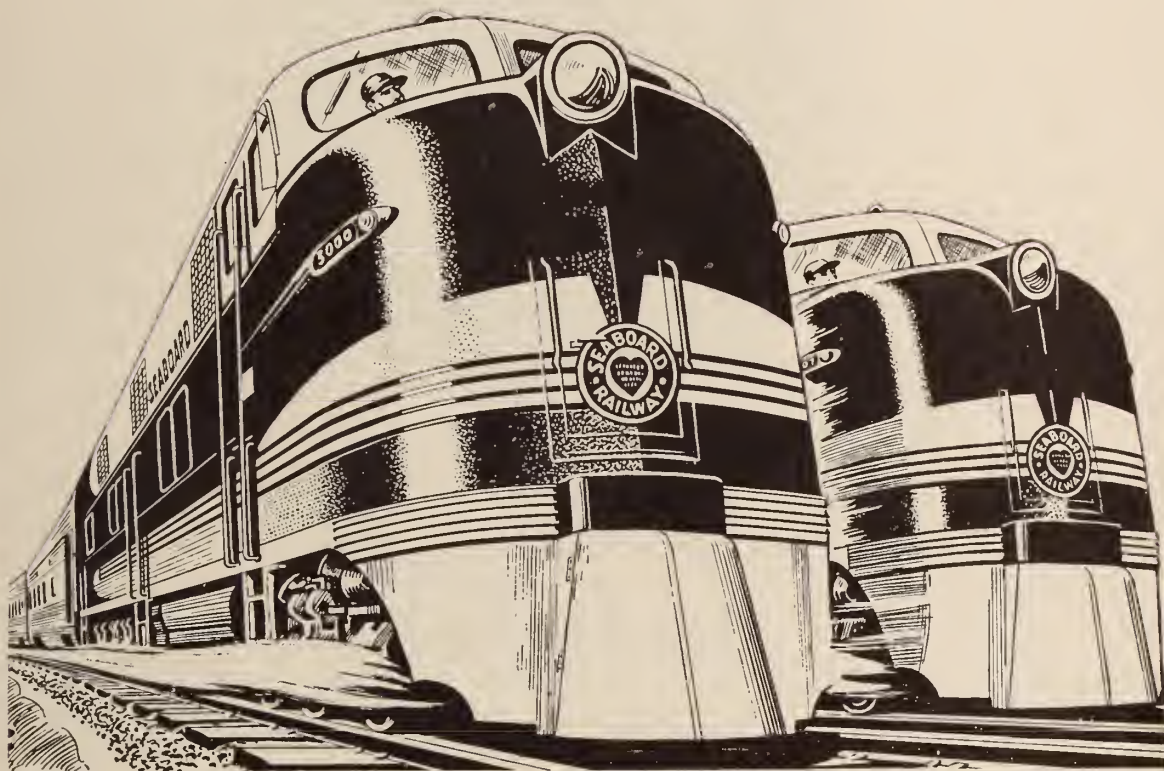
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## APPENDICITIS

L. M. GABLE, M. D.

St. Petersburg

### HISTORY

The first reported case of appendicitis observed during life is the classical one of Mestivier in 1759. The incision and evacuation of old encysted collections of pus in the right iliac fossa were practiced as far back as the beginning of the Christian era. The treatment by incision and drainage at the point of fluctuation was practiced and taught by Dupuytren, but the idea of incising the tumor before fluctuation appeared did not occur to him or his followers. The first decisive step in the direction of modern methods was taken by a London physician, Hancock (*Lancet*, 1848) who after making a diagnosis of inflammation of the appendix, incised the mass in the right iliac fossa without waiting for fluctuation to appear. The first operation on the appendix performed in the U. S. was done by R. J. Hall, of New York on May 8, 1886. The patient was a boy of 17 years who had had an irreducible hernia for several years. During the course of the inflammation the hernia became strangulated; he was operated upon for strangulated hernia, and the appendix was found. The first successful laparotomy followed by removal of the appendix, undertaken with that possibility in view, was done by Thomas G. Morton, of Philadelphia, on April 27, 1887.

In the year 1886 Reginald Fitz of Boston, read before the Association of American Physicians, his paper on *Perforating Inflammation of the Vermiform Appendix*, in which the word "appendicitis" appears for the first time. For many years prior to this time, abscess in the neighborhood of the cecum had been familiar under the name of "typhlitis" and "perityphlitis." That the appendix might be responsible for the abscess had been demonstrated by others. However, even those who advised incision and drainage recognized the appendix as the essential lesion. It remained for Fitz to see and demonstrate that the ap-

pendix itself was almost certain to be the source of this process.

### ANATOMY

The appendix of man is a vestigial organ related to the large cecum of herbivorous animals. In fetal life, it forms the end of a pouch—the cecum—which buds from the large intestine. Toward birth, the cecum enlarges without a corresponding growth of the appendix, a disproportion which continues to increase up to adolescence. The appendix is a hollow tube, having in general the structure of the large bowel. Its length is quite variable. It averages from 3 to 4 inches, but may be a mere stump, or as long as 9 or even 10 inches. There is definite proof that an appendix may appear normal to the naked eye, both in external appearance and even when cut into, and may yet be a site of active inflammation. On section the lumen is seen to be Y-shaped, and is surrounded by the mucosa which is about 1 mm. in diameter. Separated from the mucosa by the somewhat open submucosa is the muscular coat, consisting of an inner circular and outer longitudinal layer. The peritoneal coat can hardly be seen by the naked eye, and under it is the equally thin subserous layer. The blood supply to the appendix is from the appendicular artery, a branch of the ileocolic artery. The lymphatics of the appendix form a large plexus in the mucosa and submucosa and follow along the blood vessels to the glands along the aorta.

The position of the appendix varies considerably. As a rule, it springs from the inner and posterior aspect of the cecum about 1 inch from the ileocecal valve, and points upward and to the left towards the spleen. It may be retrocecal in position, passing upwards behind the cecum and ascending colon. Such a position favors the localization of an appendicular abscess. Or it may hang down over the brim of the pelvis, with the danger of infecting the pelvic peritoneum and viscera in case of inflammation. These are the principal positions of the appendix, but when the mesentery of the cecum is abnormally long and lax it may be found in almost any part of the abdomen.

## PHYSIOLOGY

The appendix has no known use and its absence has no effect upon health or the intestinal function. However, various suggestions as to its functions are: secretory, a digestive secretion, an internal secretion and a secretion to eliminate bacteria; the same physiological cycle of changes as in the other parts of the digestive tract. After adolescence, the abundant lymphoid tissue begins to disappear, an atrophic process which may lead with advancing years to an obliteration of the lumen, in whole or in part. As a rule, obliteration proceeds from the tip toward the base, but in case the base is first affected, a part of the appendix may be shut off as a closed sac.

## ETIOLOGY

It is a curious fact that although appendicitis is such a very common disease the etiological factors still remain vague and indefinite. The frequency of the disease is only of recent date. It is estimated that 18,000 to 20,000 lives are lost from appendicitis annually in the United States.

The national distribution of the disease is interesting. It is common in highly civilized countries such as the United States, Great Britain, France and Germany. In Denmark and Sweden it is lower. In Spain, Greece, Italy and the rural parts of Rumania it is very low. It has been found that there is one case of appendicitis in 22,000 patients among Rumanian peasants, while in the cities of Rumania it has been found to be one case in every 22 patients. McCarrison states that during the nine years that he practiced among the hill tribes of northwest India he never saw a case of appendicitis. In Asiatics, Africans, and Polynesians it is very rare, unless they take to European foods; then it becomes common. In wild animals it is rare or unknown. In animals in captivity it is common, especially among the apes in zoological gardens. In regard to the prevalence of acute appendicitis in civilized communities and in cities as compared with uncivilized communities and rural districts it may be said that in the former proteins are consumed, in the latter carbohydrates. Post-mortem statistics suggest that fibrosis and scarring due to mild attacks of inflammation are common in all nations, but the urgent,

gangrenous type is confined to the meat eating peoples.

As regards the exciting cause there are two main factors, obstruction and infection. The experimental work of Wangenstein and Bowers coupled with observation on human cases goes to show that obstruction plays an all important part, especially in gangrenous and perforating appendicitis. In man it appears that pressure-distention is the exciting factor, bacterial invasion of the injured wall being a secondary event. According to this view, acute appendicitis is a form of closed loop intestinal obstruction. Obstruction may be due to a concretion, to swelling of the abundant lymphoid tissue, to contraction of a sphincter-like mechanism at the base of the appendix, to fibrous contraction of the proximal end from previous attacks, to kinking of the appendix by a band or fold, and occasionally to masses of *Oxyuris vermicularis*.

Although the importance of obstruction has been emphasized, the possibility of hematogenous infection from the throat, tonsils, etc., is by no means excluded. Not infrequently an acute attack is preceded by a sore or septic throat.

Acute appendicitis is more than twice as common in the male as in the female; this may be due to the fact that young adult male is more subject to strain and trauma and that his diet is usually richer in protein than that of the female. Appendicitis may occur at any age, but it is rare in infancy and old age. It is commonest during the second and third decades.

Formerly the colon bacillus was considered the most important causative organism; now the streptococcus is being emphasized more. Dutton states that very probably one of the common initiating lesions of the appendix is an allergic reaction.

## PATHOLOGY

Any attempt to classify the various types and degrees of inflammation of the appendix is subject to controversy. Boyd classifies inflammation of the appendix into the three following classes: (1) catarrhal appendicitis, (2) diffuse appendicitis with which may be associated ulceration or gangrene, and (3) appendicitis with stenosis.

In acute catarrhal appendicitis the inflammation is confined to the mucous membrane.



The appendix is slightly swollen and the subperitoneal vessels are dilated and tortuous. The mucous membrane is swollen, edematous and congested, and the surface is frequently covered with mucus. A resolution may be complete, but residual changes are often left which predispose the appendix to subsequent diffuse attacks of a more serious character.

In acute diffuse appendicitis the appearance of the appendix is very different from that seen in the catarrhal stage. The whole organ is large, being elongated and thickened; the color is bright or dark red, and there may be a purulent exudate on the peritoneal surface. Under the peritoneum there may be extravasations of blood, and perhaps yellowish spots indicating formation of an abscess. The lumen is filled with mucopurulent material. Microscopically all the coats are congested, edematous, and infiltrated with inflammatory cells. The vessels are often thrombosed, a condition which may result in the formation of septic emboli and pyemic abscesses in the liver. Gangrenous appendicitis is merely a further stage of the acute diffuse variety. There is death and putrefaction of the tissues of the appendix, either local or general, due in every case to interference with the blood supply. Perforation may occur at any stage of acute appendicitis. It is due to necrosis of the coats of the appendix, of which the chief cause is the pressure of a concretion. It is commonest at the tip, but may occur at any part.

Appendicitis with stenosis is often called chronic appendicitis, although chronic inflammatory changes are not actually going on. The appendix is damaged and fibrosed, and is liable to recurring attacks of inflammation which vary in severity from the very mild to the very severe. The diagnosis of chronic appendicitis has become one of exceeding frequency, and it is one which is often as difficult to refute as to confirm. Even when the appendix is in the hands of the pathologist he may find it difficult to say whether the specimen should be considered one of chronic inflammation. The most characteristic feature is the thickening and rigidity of the organ. There may or may not be adhesions; when present they are always an indication of previous inflammation. The microscopic picture

varies considerably, but fibrosis is the dominant feature.

Hertzler, in a very penetrating study of chronic appendicitis written from the viewpoint of a pathologist as well as a surgeon, gives the clinical picture presented by one writer as nervousness, headache, melancholia, irritability, insomnia, dizziness, general weakness, poor appetite, inability to think clearly and habitual constipation. "I become afflicted," remarks Hertzler, "with all these symptoms whenever I contemplate the picture of chronic appendicitis."

#### PATHOGNOMY (CLINICAL MANIFESTATIONS)

In any case of suspected appendicitis one must consider carefully: (A) the history immediately prior to the onset of pain; (B) the symptoms of the attack and the local signs; and (C) the order of occurrence of the symptoms.

(A) There is frequently a history of indigestion, "gastritis," or flatulence for a few days prior to the onset of the attack. It may be elicited that frequent slight attacks of pain have been experienced in the appendicular region. A history of unusual irregularity of the bowels is often obtained. Sometimes there is constipation, at other times diarrhea.

(B) The symptoms and local signs of the attack are:

- Pain (epigastric, the right iliac).
- Vomiting-nausea-acute loss of appetite.
- Local deep tenderness (per abdomen or per rectum).
- Local rigidity of muscles (inconstant).
- Local distension (inconstant).
- Superficial hyperesthesia (inconstant).
- Fever.
- Constipation.

The pain in the majority of cases is first referred to the epigastric or umbilical region, and only later is localized in the right iliac fossa. The localization of the pain to the right iliac region usually takes place some hours after the onset of the diffuse pain in the epigastric or umbilical regions. In the case of an appendix situated in the pelvis a rectal examination will frequently elicit pain on pressing the inflamed organ. Charles McBurney said that the point of maximum tenderness could be ascertained "by the pressure of a single finger-tip," and that this point, in the average adult, is "almost exactly two inches from the anterior iliac spine, on a line drawn from this process through the umbilicus."

Vomiting generally occurs in the early stages of the attack, but usually a few hours after the initial pain. Many patients do not vomit but instead have a sensation of nausea or marked loss of appetite. In general the severity and frequency of the vomiting at the onset of an attack of appendicitis indicates the degree of distention of the appendix and consequently the immediate risk to the patient that perforation may occur.

Local muscular rigidity over the inflamed area is frequently present, but is by no means a constant symptom in the initial stages. In most cases the extreme degree of muscular rigidity coincides with commencing peritonitis, though undoubtedly it may exist when no peritonitis is present.

Fever may not be present at the beginning of the attack, but nearly always develops before twenty-four hours have passed. Before rupture has occurred the temperature does not usually go much above normal, 2 or 3 degrees Fahrenheit being the average elevation. In any suspected case the temperature should be taken every two or four hours, and if it rises in a gradual manner it is a point in favor of appendicitis.

The pulse is only slightly, if at all, accelerated in the early stages; it may be normal in every way, even though the temperature be raised. Any continued or decided acceleration of the pulse generally corresponds with the occurrence of local peritonitis; to wait for such alteration is therefore to sacrifice the best time for operation.

When the appendix is acutely inflamed gaseous distention of the cecum is frequently present. This local distention is due partly to the excessive formation of gases by the active bacterial decomposition of the content of the cecum and the appendix.

(C) The order of occurrence of the symptoms is usually as follows:

1. Pain, usually epigastric or umbilical.
2. Nausea or vomiting.
3. Local iliac tenderness.
4. Fever.
5. Leukocytosis.

As a rule, but not always, the white cell count is elevated and a differential shows increased polymorphonuclears. A Schilling blood count may be helpful in showing a shift to the left when the white cell count seems otherwise normal. But these tests may

not be conspicuous in the early stages of appendicitis. As the disease progresses, a more rapid pulse with a rising temperature usually occurs. Then the white cell count may be elevated and the Schilling shift may be valuable. However, anyone who demands all of these symptoms or even a majority of them in every case will undoubtedly miss many diagnoses.

In acute appendicitis the sedimentation rate is not increased. However, as the process spreads beyond the appendix, the rate rises and after the appendix is perforated the sedimentation increases rapidly. At the present time it does not seem safe to put much reliance on the sedimentation rate as a diagnostic aid of appendicitis.

#### DIFFERENTIAL DIAGNOSIS

Conditions that may simulate acute appendicitis may be arranged for the purposes of diagnosis into seven well-defined groups:

I. The following pathologic conditions of the gut-tube may occasion an erroneous diagnosis of acute appendicitis:

1. Gastroduodenal ulceration.
2. Cholecystitis and pancreatitis.
3. Neoplasm of colon, particularly of the cecum and ascending colon.
4. Acute mesenteric adenitis.
5. Meckel's diverticulitis.
6. Intestinal obstruction.
7. Hyperplastic tuberculosis of cecum.
8. Regional ileitis.
9. Ulcerative colitis.
10. Spastic colitis.
11. Chronic constipation.
12. Intussusception.
13. Diverticulitis.
14. Mesenteric vascular occlusion.

II. Conditions having an etiologic origin from the gut-tube, but with the major pathologic condition in other areas or organs, which may cause incorrect diagnosis of appendicitis, are:

1. Subphrenic abscess.
2. Septic pyelophlebitis.
3. Retroperitoneal phlegmon.
4. Perinephritic abscess.
5. Hepatic abscess.
6. Amebiasis.

III. Conditions arising from the retroperitoneal tissues, and simulating acute appendicitis may be:

1. Acute hematogenous infection of the kidney.
2. Nephrolithiasis.
3. Renal neoplasm.
4. Nephroptosis—Dietl's crisis.
5. Ureteral calculus or stricture.
6. Perinephritic abscess.
7. Retroperitoneal neoplasm, such as lymphosarcoma.



8. Right-sided pyelitis in children and women.
9. Mesenteric adenitis.

IV. Conditions, primarily thoracic, with symptoms of referred pain, simulating acute appendicitis are:

1. Pneumonia.
2. Pleurisy.
3. Chronic tuberculosis of lungs.
4. Cardiac disease.
5. Intercostal neuralgia.

V. Conditions arising from disease of the peritoneum and pelvis which may give the appearance of acute appendicitis are:

1. Tuberculous peritonitis.
2. Tubal disease.
3. Ectopic gestation.
4. Ovarian cysts.
5. Pneumococcus peritonitis.
6. Torsion of omentum.
7. Gangrene of appendices epiploicae.
8. Pelvic allergy.

VI. Conditions arising from cerebrospinal disease, which may give the appearance of appendiceal inflammation are:

1. Tabes dorsalis.
2. Spinal tumor.
3. Incipient meningitis.
4. Brain tumor.

VII. General systemic conditions or remote disease, simulating appendicitis, include:

1. Sepsis, infarcts of spleen, etc.
2. Lead poisoning.
3. Incipient diabetic coma.
4. Uremia.
5. Visceral manifestations, such as erythema oxidativa and angioneurotic edema.
6. Acute follicular tonsillitis.
7. Herpes zoster.
8. Peritonismus.

Many of the conditions indicated in this synoptic presentation are so rare that they are not considered in the ordinary diagnostic survey. The conditions most frequently mistaken for acute appendicitis are insidious perforation of gastric and duodenal ulcers (particularly the latter), atypical attacks of biliary colic, central pneumonia, diaphragmatic pleurisy, perinephritic abscess, acute salpingitis, ectopic gestation, hemorrhagic cyst of the ovary, pyelitis and ureteral calculus on the right side.

#### TREATMENT

Acute appendicitis without perforation should be treated by prompt appendectomy before the disease has spread beyond the appendix wall. A rare exception to this rule is the occasional patient with the complicated disease which would make an early operation so hazardous that the danger of operation would be greater than nonoperative

treatment. The most convincing evidence to support the rationale of early operation before perforation is the low mortality rate for this group of patients which rarely exceeds one per cent.

In cases of appendicitis with perforation and local peritonitis without distention the general condition of the patient should be the deciding factor concerning the time to operate. If there is little or no distention, appendectomy is indicated and results in a lower mortality and morbidity than the non-operative or Ochsner type of therapy. Distention is the greatest single indication of danger in developing peritonitis. As long as a bowel retains its tone and contractility, its blood supply is good. The more a bowel is distended the greater the interference with its blood supply which may progress to a point at which necrosis and toxic absorption begins. A bowel that is active will not absorb toxic products from its lumen.

In cases of appendicitis with perforation and abscess formation with a mass in the appendix region there is no need for emergency surgery. In a large percentage the masses will completely disappear in one to two weeks. Deferred operation is advisable to avoid the possibility of spreading infection to the peritoneum and abdominal wound. If the mass grows larger or the findings indicate an abscess that is not receding, drainage is indicated, and the removal of appendix if it can be done without trauma. The diseased appendix usually forms a part of the abscessed wall and by its removal a protecting barrier against infection is disturbed. If the mass disappears after a few days of conservative treatment, operation may be more safely done two to three months later.

In cases of appendicitis with perforation and diffuse or spreading peritonitis there is no set rule that can be followed in every case. The individual surgeon must choose between operative and nonoperative treatment. There will be deaths with either type of treatment. The forms of treatment available to the surgeon in acute peritonitis are as follows: (1) operation, (2) restoration and maintenance of water balance, chemical balance and nutrition, (3) prevention and relief of distention, (4) application of heat to the

abdomen, (5) serum therapy, (6) oxygen therapy, (7) bed posture and (8) blood transfusion.

In regard to operation in diffuse peritonitis it seems reasonable to believe that the result of operation to a patient seriously ill with peritonitis might be more harmful than the presence of a perforated appendix. If a localized abscess develops, drainage at the proper time is indicated. Any attempt to cleanse the intestines or remove the peritoneal exudate by irrigation is contraindicated. The use of enterostomy to drain the distended bowel in diffuse peritonitis is a doubtful procedure.

The disturbances in water, chemical and food balance are best treated by parenteral administration of sodium chloride and dextrose solutions either by the intravenous or subcutaneous route. The quantity of water, sodium chloride, and glucose necessary will naturally vary with individual patients. It is possible to give too much water and sodium chloride. General edema or edema of the lungs may result with excessive hydration when the solutions given contain too much sodium chloride. If edema develops, the sodium chloride intake should be reduced or discontinued and the injected solutions continued as 5 per cent dextrose.

Since over-distention of the intestine in peritonitis is the most dangerous element of the disease it merits special attention. Decompression of the stomach and upper intestine by the continuous nasal catheter suction method, frequently referred to as the Wangenstein method, is of great value. At the present time drugs such as pitressin, physiostigmine and others are of great value in maintaining peristalsis in order to alleviate distention. However, the indiscriminate use of peristaltic stimulants in all cases of abdominal distention is poor therapy and they should be used with great caution in cases of peritonitis. Moist or dry heat applied to the distended abdomen of peritonitis is a comfort to the patient and may favorably influence peristalsis and reduce infection.

Serum therapy such as bacteriophages are being used, but more experimental and clinical observation are desirable to establish their true value. Oxygen therapy should be used

to combat anoxemia from reduced vital capacity, morphinization, abdominal distention and toxemia. A semi-sitting or Fowler position increases vital capacity and adds to the patient's comfort. Blood transfusions are used to combat anemia and also help to increase the total blood protein. Enemata and colonic irrigations are contraindicated in the early treatment of acute peritonitis. Frequent enemata distress the patient and in many instances increase distention. The insertion of a rectal tube causes little discomfort and will frequently enable the patient to expel gas from the lower colon.

It is interesting to note that sulfanilamide has been used in cases of appendiceal abscesses. Cokkinnas reported eight such abscesses treated with sulfanilamide none of which had to be drained, and only one developed a relapse after two months, which was treated by appendectomy.

No attempt has been made to discuss the various operative techniques in this paper. The success of the operation depends more upon the skill and surgical judgment of the surgeon than upon the technique employed. Likewise, this paper does not permit a discussion of the merits and disadvantages of the many types of anesthesia in use today.

In the treatment of appendicitis fewer deaths will result from occasional unnecessary laparotomies than from over-cautious delays which allow acutely inflamed appendices to rupture.

#### COMPLICATIONS

The complications of appendicitis can be any disease to which human tissue is heir, but the most common complications are those of residual abscesses, intestinal obstruction, pyelophlebitis, fecal fistula, and secondary hemorrhage.

Residual abscesses are areas of peritonitis undrained at the time of operation or less often, infected subsequent to operation. They are to be looked for in the pelvis, the right or left loin and occasionally in the sub-diaphragmatic spaces. Intestinal obstruction is a familiar complication and may be paralytic or mechanical. The paralytic type is usually the result of peritonitis and has been previously discussed. Mechanical obstruction is unusual and is due to fresh adhesions and



consequent kinking of the bowel. Pyelophlebitis, a local thrombosis of the portal veins in the region of the appendix, is a rare but very dangerous complication. Infected emboli may become detached and carried to the liver, where they are likely to form single or multiple abscesses. A thrombophlebitis of the iliac and femoral veins, the familiar "milk-leg", does not seem to occur more often after septic processes than clean ones.

Fecal fistula from an open appendix stump is not uncommon, since the base of the appendix is often so necrotic that the fecal wall cannot satisfactorily be repaired. Such a leak leads to wound infection and results in a nasty fecal discharge, which may be very persistent, but since drainage has almost inevitably been established, life is not threatened. Secondary hemorrhage may take place, usually from the deep epigastric artery, which is often exposed at the lower end of a right rectus incision. The pathological complications of appendicitis may themselves prove to be troublesome and more deadly than the local lesions in the appendix.

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#### MULTIPLE BLOOD TRANSFUSIONS IN ACUTE LEUKOPENIA OF ADULT LOBAR PNEUMONIA

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During the past few years, a number of articles have been published on blood transfusion in pneumonias in infants and children but little has been said of transfusions in adult pneumonias. Arena<sup>1</sup> states that for three years at the Duke Hospital one or more transfusions were given to infants and children with primary pneumonia. Prompt and marked symptomatic improvement usually followed and the patients appeared more comfortable. The temperatures fell within twenty-four hours after the transfusions by crisis in fifteen of twenty-four cases and within forty-eight hours in the other nine. The average duration between the onset and crisis was 7.9 days compared to 9.9 in a control series when no transfusions were given. Severe dyspnea and cyanosis improved with the transfusion. Acuna and Fernandez<sup>2</sup>

used repeated immunotransfusions in children. The transfusions were repeated two to six times at intervals of one to four days. Blood was taken from donors four to six hours after injection of pneumococcic vaccines. They concluded that immunotransfusions were of therapeutic value in pneumonia, that better results were obtained after early administration and that they must be repeated. Crocker and his co-workers<sup>8</sup> state that non-specific immunotransfusions seem to abort pneumonia.

There are a number of theories as to the mode of action of transfusions. Murano<sup>4</sup> believes they stimulate organic defenses, modify the colloidal equilibrium of blood and tissues, and supply the blood with proteins, ferments, vitamins and immunofacient substances. Arena<sup>1</sup> believes they possibly stimulate an increase in segmented neutrophils. The ratio of the segmented to the non-segmented forms appears to vary inversely with the severity of the infection and the ultimate outcome. They may be a form of serotherapy introducing neutralizing antibodies or causing nonspecific protein shock. They may supply cells to carry needed oxygen to tissues.

Indications for transfusions are numerous. Clendenen<sup>5</sup> believes they are indicated in critical periods of disease such as sepsis and critical pneumonias.

Leukopenia occurs in certain infections such as typhoid and paratyphoid fevers, malaria, and measles; intoxications such as benzol and arsenic poisoning and inanition; diseases of the hematopoietic system such as aplastic anemia and agranulocytic angina. Pepper and Farley<sup>6</sup> state that when the body is overwhelmed, leukocytosis is replaced by leukopenia with lowering or disappearance of neutrophils. This may occur rapidly in acute infection and denotes bone marrow failure. They say that the mortality rate is high and the prognostic significance grave in absence of the usual leukocytosis in lobar pneumonia or when the early leukocytosis is replaced by a low white count with a low neutrophilic percentage. Musser<sup>7</sup> and Osler<sup>8</sup> report a higher death rate with moderate or low leukocytosis than with a marked increase in leukocytes. The white count varies from 20,000 to 30,000 in the average adult.

Leukopenia may be classified as primary in such instances as agranulocytic angina<sup>9</sup> or sec-

ondary in cases caused by benzol and other poisons which depress the bone marrow and by certain infections. It may also be classified according to the causative mechanism; unequal distribution, increased destruction or decreased production. Unequal distribution is usually the result of the entrance of some foreign protein into the blood stream. The cells are found mainly in the liver and spleen. The white cells may collect in organs so that they might better engulf circulating bacteria. This is shown after intravenous injections of typhoid bacilli or foreign proteins. A subsequent leukocytosis appears. The change is rapid and constant but the mechanism is not understood. Decreased production occurs in aplastic anemia or when the bone marrow is depressed after benzol poisoning, heavy irradiation, etc. Increased destruction is not yet clinically recognized. More information as to the fate of the white blood cells is needed.

#### CASE REPORT

The patient, a white male, 59 years of age, presented himself with fever and a pain in the chest.

On the day he became ill, he arose at 4 a. m. feeling perfectly well. He left Charlotte, North Carolina by automobile at 6 a. m. About eight o'clock, after driving two hours, he became very thirsty and drank three glasses of water. This was unusual. He began to tire and within an hour had severe aching pains in the right lower chest anteriorly. The pains were continuous but felt like knives sticking into him on respiration. About 10 a. m. he was seen by a doctor who gave him some morphine by mouth. A half hour later he became nauseated and vomited. He does not remember much from this point on, but states that he took several morphine tablets and vomited in a short while each time. He felt chilly but had no definite chill. He arrived at Winter Park, Florida about 9 p. m. after riding 565 miles. He was first seen at one o'clock the following morning and was admitted to the hospital at 2:30 a. m.

His father died from pneumonia at thirty years of age. His mother died from tuberculosis at forty. One sister died from tuberculosis twenty years previously. He had two sisters and one brother living and well. His wife was living and well.

He had had measles and typhoid fever and three years previous to present illness he had a peptic ulcer. This was pronounced cured after two years. He had a maxillary sinus operation thirty years previously and two hemorrhoidectomies.

Physical examination revealed a slender, acutely ill white adult male with an anxious expression. His temperature was 101.6; pulse, 104; respiration, 26. Hearing was impaired in both ears. There was a friction rub in the right lower chest from the anterior axillary line to the mid-clavicular line. There was impaired resonance over the same area. Traumatic scars were present over both tibiae. The physical examination did not otherwise yield observations of importance.

Laboratory reports revealed a white blood count of 13,800. The differential count showed 94 per cent neutrophils of which there were 18 juvenile cells, 48 stab cells and 28 segmented cells. The red blood count was 4,800,000 and the hemoglobin was 90 per cent. The urine analysis was normal. Pneumococci were seen in the sputum. Typing by the Neufeld method was nega-





FIG. 1. Taken the second day of illness.



FIG. 2. Taken the sixth day of illness when the white blood count dropped to 4,500

tive to the sera of types 1 to 8 inclusive. These were the only sera available. Roentgenograms revealed a pneumonic process in the right lower lobe.

That afternoon he was raising prune-juice sputum. The following day he was drowsy most of the time and complained of chest pain and hiccoughs. On the fourth day of his illness, he was irrational a greater part of the time and the hiccoughs were very difficult to control. He was very restless and picked at the bed covers. Roentgenograms showed almost a complete involvement of the right lung. The white count was decreased to 11,600 while the differential count remained essentially the same. By the sixth day, his white count had dropped to 4,500. The differential count revealed 88 per cent neutrophils, 8 of which were juveniles, 42 were stabs and 37 were segmented cells. The red blood count was 4,000,000 and the hemoglobin was 75 per cent. The patient was becoming progressively worse clinically. Roentgenograms were about the same. The patient was immediately typed and a transfusion was done with 325 cc. citrated blood by the indirect method. On the seventh day, the white blood count had increased to 8,750. The juveniles decreased to 6 and the stab cells decreased to 33, while the neutrophils remained at 88 per cent. The patient was less restless and more ra-

tional. On the eighth day his white blood count dropped to 8,300. He seemed somewhat better, although he complained of more pain in his chest. Hiccoughing had stopped. Roentgenograms showed an involvement of the left upper lobe. Another transfusion of 300 cc. was given. On the ninth day, his white blood count was 7,500. The following day it was 8,000 with a decrease of neutrophils to 79 per cent, juveniles to 5 and stabs to 28. The patient was restless and complained of chest pain. On the eleventh day, his count had dropped to 6,800. Another transfusion was done with 350 cc. of blood. None of the donors were known to have had pneumonia. Roentgenograms showed considerable improvement. The following day his white blood count jumped to 10,750. The patient continued to improve so that he could be discharged from the hospital on the twenty-second day. At that time the white blood count was 6,800 and the neutrophils were 64 per cent with no juveniles and 15 stabs.

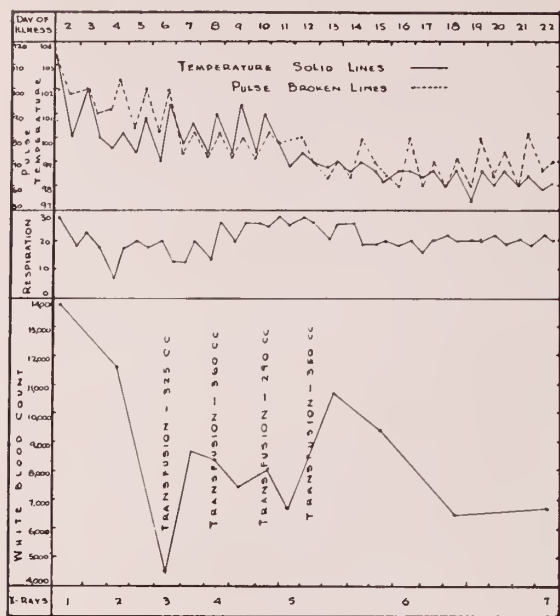
Other treatment consisted of intravenous saline and glucose, forced fluids, vitamins, sodium bicarbonate, morphine, codeine, atropine and enemata.

#### BLOOD COUNT ON VARIOUS DAYS OF ILLNESS

| Day of Illness | Red Blood Count | Hemo-globin | White Blood Count | Total neutro-philes | Juvenile | Stab | Seg-mented | Lympho-cyte | Mono-cyte |
|----------------|-----------------|-------------|-------------------|---------------------|----------|------|------------|-------------|-----------|
| 2              | 4,800,000       | 90%         | 13,800            | 94                  | 18       | 48   | 28         | 6           | —         |
| 4              | 4,520,000       | 88%         | 11,600            | 91                  | 16       | 38   | 37         | 7           | 2         |
| 6              | 4,000,000       | 75%         | 4,500             | 88                  | 8        | 42   | 37         | 10          | 2         |
| 7              |                 |             | 8,750             | 88                  | 6        | 33   | 49         | 10          | 2         |
| 8              |                 |             | 8,300             | 83                  | 3        | 25   | 53         | 14          | 3         |
| 9              |                 |             | 7,500             | —                   | —        | —    | —          | —           | —         |
| 10             | 4,920,000       | 94%         | 8,000             | 79                  | 5        | 28   | 46         | 17          | 4         |
| 11             |                 |             | 6,800             | —                   | —        | —    | —          | —           | —         |
| 12             |                 |             | 9,600             | 87                  | —        | 24   | 53         | 4           | 5         |
| 13             |                 |             | 10,750            | —                   | —        | —    | —          | —           | —         |
| 15             | 5,540,000       | 98%         | 9,350             | 71                  | —        | 13   | 58         | 25          | 3         |
| 18             |                 |             | 6,500             | 62                  | —        | 18   | 44         | 30          | 8         |
| 22             | 5,520,000       | 94%         | 6,800             | 64                  | —        | 15   | 49         | 34          | 2         |

Eosinophiles and basophiles appeared only twice and were within normal limits so they were not included

## COMPOSITE CORRELATED CHART



## COMMENT

Multiple blood transfusions are of definite therapeutic value in lobar pneumonia, when the body defenses have been overwhelmed and there is profound toxemia, particularly when there is an associated leukopenia. In this case, they were probably life-saving when the white blood count dropped from an early moderate leukocytosis to 4,500 on the sixth day of illness with the patient rapidly becoming worse and the pneumonic process progressively extending.

Transfusions are not to replace serum treatment when a specific serum is indicated. They are recommended only as an additional measure in the treatment of pneumonia, especially as a means of combatting overwhelming toxemia and leukopenia. In this particular case, serum was not used because the patient was not of a type for which specific serum was available. At the time this patient was ill, sul-fapyridine was not in use.

The causes of leukopenia are not well understood. In this case, it seemed to be mainly due to an increased destruction of white blood cells in excess of their production since there was a marked reduction in leukocytes as compared to erythrocytes while the percentage of neutrophils, juveniles and stab cells were only

moderately reduced. It is not possible from these data to rule out unequal distribution. The bone marrow probably was also slightly depressed due to toxicity of the disease or inanition. Whatever the mechanism, there was a distinct failure to mobilize white cells in the blood stream. Whether the differential white blood count in this case will prove to be an exception or the rule in the leukopenias of pneumonia and other septic processes can be determined only by frequent complete blood counts in additional cases.

## CONCLUSIONS

1. The progress of pneumonia should be followed by frequent blood count to detect any marked fall in the white count. Leukopenia often denotes beginning failure of the patient to cope with the infection.
2. The clinical condition of the patient and the leukopenia improved after blood transfusions.
3. Transfusions are to be considered an additional measure in selected cases. They are in no way a substitute for serum, chemotherapy or general measures. However, in view of the spectacular advances in serum and chemotherapy, measures such as blood transfusions, particularly in critical cases with leukopenia, should not be overlooked.

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## THE CROSS-EYED CHILD

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This paper is presented in the interest of the cross-eyed child, a poor unfortunate, handicapped psychologically as well as physically—the strabismic child who is so often neglected until he arrives at an age when his condition is incurable. His problem, arising out of lack of understanding and prejudice, is a challenge to you who see, care for, and advise these children and their parents. This paper's object is to impress upon the general practitioner, as well as upon the ophthalmologist, the importance of early definite treatment of these cases and to warn of the evil that waiting brings to these afflicted youngsters.

The disfigurement of strabismus merited the attention of the very earliest medical writers. Hippocrates noted it and considered it a hereditary taint, observing that the cross-eyed child often had a cross-eyed parent. Indeed, squint is frequently the product of those hereditary susceptibilities that have given the child a refractive error with a defective fusion faculty, but its etiology is not yet a settled fact—that, in spite of the circumstance that every parent can cite a definite cause in his child's case, be it whooping cough, measles, convulsions, fright, a fall, or any of many others. A failure to concur often makes one seem an unknowing consultant, yet these can be considered only as contributing or precipitating factors, not etiologic. Actually, several theories have been advanced as to the cause of strabismus.

Normally, the eyes are so related in their movements that one is never moved independently of the other. When one eye fixes upon an object that impulse causes the associated muscles of the other eye to react simultaneously and both eyes become fixed upon the same object. In squint it used to be thought that the deviation was due to a too strong or overacting muscle that acted in excess of its associated antagonist to cause the eye to turn in or out.

Yet, physiologically, it should have happened that the increased demands made on the weaker muscle should have caused it to

develop increasing strength, as do all muscles everywhere else. Obviously, there were factors other than the careful coordination of the ocular muscles. Donders in the nineteenth century, observed that the convergent squint was almost always associated with hypermetropia, while divergent squint was seen usually in myopia and that they were often cured by the correction of the refractive error with lenses. Yet, though hypermetropic eyes tend to deviate inward, due to an excessive converging power usually found with hypermetropia, every hypermetropic individual does not develop squint. There is yet another factor. While muscular anomalies and refractive errors contribute, the other essential factor in the interest of harmony is single binocular vision by fusion. Though each eye sees singly, each image is blended or fused into one, as though the projection were from a "cyclops" eye placed midway between the two eyes. The essentials for binocular vision are two healthy maculae, in two eyes whose motor functions are in perfect order, presided over by a healthy brain.

The ocular muscles so regulate the positions of the eyes that objects fall upon corresponding retinal points to stimulate corresponding retinocerebral elements. Such perfect sensory-motor coordination paves the way for single binocular vision, but a special sense is essential to unite the images so received. This faculty that unites the two retinal images into one mental picture, is called fusion and is present in all normal individuals. It begins to assert itself six to eight weeks after birth, is well developed by the twelfth month of life and complete before the end of the seventh year, so that the instinctive tendency to blend the images formed in the two eyes, keeps the eyes straight. When the fusion faculty is well developed, nothing but an actual muscular paralysis can cause the eyes to deviate. Through it, the main objects on which the eyes are fixing are blended into a single image and the other points in front and behind are merged into single impressions to give depth and the relation of objects to each other. Single binocular vision is essential for clear and for comfortable seeing. Should one eye deviate, the images no longer fall on corresponding retinal points, and the instinctive active desire for bin-

ocular single vision is antagonized by a tendency to diplopia, headache, vertigo and other symptoms of ocular discomfort. But nature abhors the state of diplopia, the patient seeks relief from his ocular aches, and so the image of one eye is suppressed, is ignored—just as you voluntarily suppress the vision of your other non-sighting eye when you look through a monocular microscope—and that eye, lacking the reigning effect of binocular single vision, deviates, and the patient seeing singly and with only one eye, becomes comfortable again. Instinctively seeking comfort, he has become strabismic.

So it is that the normal process of binocular single vision made possible through the orderly action of the extra-ocular muscles, through the operation of the fusion faculty, or through the similarity of the refractive error in both eyes, becomes the motor anomaly known as squint when any of these mechanisms is disturbed. Commonest provocations to the overthrow of binocular vision are marked difference of the refractive error of the two eyes, vertical muscle imbalance, lateral imbalance, violent mental disorders and convulsions, severe fright, and occlusion of the eyes for too long a period (as in congenital cataract). All these factors create a want of harmony, imperfect coordination, and a motor disturbance results. From these causes of squint arise the dangers of squint and the avenues of treatment to be considered later.

Squints for our purpose may be divided into two broad groups:

(a) Convergent squint (esotropia) in which the deviating eye turns inward, and divergent squint (exotropia) when the eyeball turns out. There may also be deviations of one visual axis above that of the other known as hypertropias. Hypertropias may be simple, or combined with inward or outward lateral deviations, as a hyperesotropia when the eye deviates not only inward, but upward.

(b) Each of these types is called monocular if, with both eyes open, the same eye habitually fixes while the other eye deviates. These usually begin in infancy, frequently during the first year, but are more common during the second and third and less in the fourth year of childhood. The fusion faculty is present but undeveloped. Vision in the

constantly deviating eye is usually markedly decreased due to lack of use.

A squint is called alternating if, with both eyes open, sometimes one eye deviates, sometimes the other. There is believed to be a total absence of fusion, while vision in each eye is usually, or can be brought to, normal. Though alternatingly, there is use of each eye, and vision is given an opportunity for exercise and development.

Whatever the type, an exhaustive and systematic examination is absolutely necessary in every case of squint. Only by such care and diligence is it possible to obtain the necessary facts for laying out a rational and scientific course of treatment to be carried out in a given case. The squint must be typed and measured precisely by the use of the perimeter, or by the screen test with prisms, detailed description of which is irrelevant to the purpose of this paper. May it suffice to say that these are aids in the determination of the type of squint, its etiology, and present guides as to future treatment. The deviation is measured at twenty feet and at thirteen inches, both under and without atropine. A squint which lessens or disappears under atropine will probably be relieved by the full correction of the refractive error. A deviation greater at twenty feet than at thirteen inches means primarily an anomaly of the diverging power, whereas one that is greater at thirteen inches indicates an excess of convergence and thereby a clue as to treatment, whether that be muscle exercise or surgery. A convergent squint greater at near than at a distance, denotes an excess of converging power, and treatment should be directed to weakening the internal recti by surgery, or to strengthening the external recti by exercise or by surgery. Were the deviation greater at twenty feet, the external recti would be weak and need strengthening, while interference with the internal recti would be ill-advised and sometimes meddlesome.

If the cross-eyed child is to develop or re-establish normal human relationship, if he is not to be laughed at, ridiculed, ostracized or made to feel inferior, if he is to develop into a healthy adult, he needs understanding and proper treatment. In the consideration of the treatment of squint there arises the question of medical or non-operative treatment versus surgical correction. Considering first the non-



operative, the most important step is educational. Every mother ought to know—and the doctor as well—that squint in her child is amenable to early treatment, that it is not a simple thing that the child will outgrow, but a very serious matter if neglected. Glasses, the use of atropine and exercise will usually cure these patients when seen early, but when neglected and vicious habits have formed, it takes years of most persistent exercise and treatment to secure the same results that could have been had if the case had been treated from its incipency. Many, if not most, of these neglected cases can never be cured except by operating, and the cure then is cosmetic, not functional. Every teacher in the graded schools ought to be taught that any cross-eyed child is a neglected child, and every physician who allows a child to grow up so, is an accomplice to that neglect. He must learn that squint is curable in its early stages. If this paper can do nothing more, may it leave with you, and with an earnest emphasis, the knowledge that the development of fusion and of central vision occurs during the first six years of life and is completed by the age of seven. The eye develops skill but not vision after then. Remember, too, that a deviating eye is not being used; there is no development without use and the exercise of vision. The eyes must be used and made to see, and how well that is done during these several years of early life, determines the visual capabilities of the eye. You have stopped growing at twenty, but your eyes have reached their maximum visual development by the age of seven. Surgery after then gives a good cosmetic result, relieves a deformity, with the loss of an eye. Yes, gentlemen, to advise a mother to let the cross-eyed child alone, that he will outgrow it, means a lost eye as far as a useful, functioning organ is concerned. Amblyopia uncorrected before the age of seven continues throughout life.

Medical or nonoperative treatment of squint is directed toward improving the visual acuity of the deviating eye and establishing fusion, or binocular single vision. The child's refraction is done most carefully, objectively, by retinoscopy under atropine cycloplegia, and the best corrective lens is worn constantly. An effort is made to improve the vision in the squinting eye by forcing its use. Some ap-

pliance, be it a bandage or pad or patch, is placed so as to occlude the better eye completely, thus compelling the use of the squinting eye. This is worn for two hours daily where amblyopia has not developed, and increased to from three to six hours or longer where there is amblyopia. The patient not only is required to wear the occluder, but also is given exercise at the near point, as drawing, painting, sewing, stringing beads, cutting out pictures, and the like, in order to re-establish central fixation in the squinting eye, by changing it from the squinting to the fixing eye. The good eye is absolutely occluded for from four to six weeks. As soon as vision has moderately improved, atropine in the good eye may replace the bandage, having the added advantage of breaking up any spasm of accommodation and of relieving excessive convergence.

When visual acuity has been brought up to 20/70 or beyond, fusion training is begun by various forms of orthoptic exercises, the most frequently used being the stereoscope with appropriate slides. No set of eyes can be put straight, and kept straight without operation, unless such exercises develop binocular vision, and little progress can be expected after the age of seven. But if the patient is under seven and a year of training has not been successful, nonoperative treatment must give way to surgery. More can be done toward a permanent cure in a few minutes in the operating room than can be accomplished in laborious months of training.

Ocular muscle surgery not only restores an anatomical defect but re-establishes a function and demands, therefore, as much scientific study and technical skill as is demanded by any branch of surgery. It must also be evident that to attain this perfection (useful binocular vision, which is the only safeguard against recurrence in these cases which come to operation) operation must be early, as early as it can be determined that the case is operative. Because an early operation means a very young child and ether anesthesia, there must be a predetermined mode of attack, a very definite method of procedure. This means accurate preoperative study and measurement of the deviation, and precisely accurate operative methods to be carried out in the operating room. There is no earliest age.

The facts are that a squint with over 15 degrees of deviation does not improve with orthoptic training; and no improvement after a year's trial warrants surgery. Usually, the longer the wait, the more unfavorable for operation conditions become. Overtense muscles become rigid, overstretched muscles become enfeebled and, most important, it is highly desirable to obtain parallelism before the developing period for the eye has passed in order to have the aid of fusion and fusion training. If these eyes are set approximately parallel, and this can be done by means of proper study and measurement beforehand and accurate operative procedure, the innate desire for binocular vision will cause even the youngest child to acquire it. The earlier the operation, the less amblyopia from non-use. The longer the eye remains crossed, the more complete is the suppression of the deviating eye, and the more difficult to create a demand for the fusion of the two images. No patient can be even approximately cured who is allowed to go with a monolateral crossed eye from three to four years of age up to twelve to thirteen or beyond. Amblyopia will be present, suppression complete, muscular changes will have taken place (hypertrophy of the internus, relaxation or atrophy of the externus in a convergent squint) and a desire for binocular vision entirely lost.

The surgical procedure is essentially orthopedic: the weakening of the stronger muscle, the strengthening of the weaker one, there being no way to control the amount of nervous stimulation to these muscles. The eyes are caused to become at least anatomically parallel and fusion training postoperatively is given to keep them so. Muscles are strengthened by advancing their insertion, or by shortening them and allowing the original insertion to remain. This latter may be done by tucking or by resection of the muscle. A muscle is weakened by tenotomizing it, and allowing it to stretch, or by recessing it from its original insertion. This is done to the antagonists just as soon as their responsibility and type of squint is determined. The amount of shortening or recession is determined by the degree of deviation. The problem is essentially easier under local anesthesia when the position of the eyes can be noted on the table. But accurate surgery

is as successful under general anesthesia if the surgeon has a thorough knowledge of his case and has previously determined the extent and type of his orthopedic procedure. To illustrate, I shall present several cases from my practice.

#### CASE REPORTS

Case 1. S. M. This patient, aged 8, had alternating convergent squint, 35 degrees for near and for distance, uninfluenced by a moderately high correction for compound hypermetropia that restored vision from 20/50 in the right eye and 20/30 in the left to normal. A resection (12 mm.) of the right external rectus, combined with a recession (5 mm.) of the right internal rectus under ether anesthesia restored both eyes to complete parallelism. No fusion sense is present.

Case 2. J. L. B., aged 19, illustrates a good cosmetic result in a now nonfunctioning eye. The deviation of the right eye present since the age of 3, and never "outgrown," was 25 degrees at 30 inches and 20 degrees at 6 feet, indicating an excess of convergence, with a secondary weakness of divergence. Vision was 20/200 in the right eye, unimprovable with correction of a moderate amount of compound hypermetropia. Fusion was essentially lacking. A liberal resection of the right external rectus (15 mm.) with a 4 mm. recession of the right internal rectus gave the excellent result shown. In spite of poor progress with orthoptic exercises, the eyes after three years continue parallel.

Case 3. A. M. C., aged 39, had been twice operated upon for a left convergent strabismus which had now become divergent (30 degrees) with limitation of rotation beyond the midline. Vision was only that of gross movements and could not be improved with glasses in spite of the absence of any organic lesions (amblyopia exanopsia). With left eye vision so poor, even though normal (with lens correction) in the right eye, there was only a rudimentary fusion sense. The left internal rectus was picked up and shortened 8 mm. by resection, while the left external rectus was recessed 5 mm. to give the good orthoptic result illustrated, and which continues after two years. Operation was successful in improving the cosmetic appearance of the patient but there was not the slightest hope of influencing vision at this very late date.

I hope that this informal consideration of the cross-eyed child has contributed a little to clarify your knowledge of the subject and shall provoke questions and discussion from the floor.

404 Blount Bldg.



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Pensacola (A) . . . . .Oct. 5  
Dunedin (D) . . . . .Oct. 31  
Ft. Pierce (E) . . . . .Nov. 1  
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**ANNUAL CONVENTION—TAMPA**

The Hillsborough County Medical Society entertained royally the doctors and guests who attended the Sixty-seventh Annual Convention of the Association. The attendance surpassed all previous records. Next month's Journal (June) will contain a complete write-up of the annual convention, proceedings of the House of Delegates, reproduction of annual reports from officers and committee chairmen, and Echoes of the Convention.

In this Journal may be found the names of the newly elected officers, President Turberville's new assignments to the Association's standing committees, and the editorial staff.

**SHORT COURSE PROGRAM  
COMPLETE**

The program is now complete for the Graduate Short Course, to be held June 24-29, 1940, at the George Washington Hotel, Jacksonville. The George Washington is completely airconditioned, a feature which the commit-

tee feels will add much to the comfort of the lecturers and attending physicians.

Dr. Raymond W. McNealy, Associate Professor of Surgery, Northwestern University Medical School, Chicago, will return to present this year's course in Surgery. Doctor McNealy will be most pleasantly remembered by those who attended the 1939 Short Course.

Another instructor popular with Florida physicians is Dr. W. T. Pride of Memphis, who gave the 1939 course in Obstetrics and will return this year. Doctor Pride is Professor of Obstetrics at the University of Tennessee College of Medicine.

Dr. Willis Campbell, Professor of Orthopedic Surgery, University of Tennessee College of Medicine, Memphis, appeared on the Short Course program in 1935. Florida doctors who heard him at that time will be pleased to know that he has consented to present the course in Orthopedic Surgery.

The course in Medicine will be given by Dr. Henry M. Thomas, Associate in Medicine, Johns Hopkins University School of Medicine, Baltimore, who comes to the Short Course for the first time this year.

Pediatrics will be presented by Dr. Daniel C. Darrow, Associate Professor of Pediatrics, Yale University School of Medicine, New Haven, who is also a newcomer.

Another newcomer to Short Course audiences will be Dr. Stuart Michaux, Professor of Clinical Gynecology, Medical College of Virginia, Richmond, who will give the lectures in Gynecology.

Dr. Paul Padget, Associate Editor, American Journal of Syphilis, Gonorrhea, and Venereal Diseases, Baltimore, will present the course in Venereal Diseases, which has been substituted for Neuropsychiatry this year. For those interested in additional work in Venereal Diseases, special clinics have been arranged on Wednesday and Friday afternoons, June 26 and 28, at 4:30 o'clock at Brewster Hospital.

Titles of lectures will be found in the Schedule which appears in this Journal.



| HOUR           | MONDAY<br>June 24                                                                                          | TUESDAY<br>June 25                                                                                | WEDNESDAY<br>June 26                                                                                                         | THURSDAY<br>June 27                                                                                                                             | FRIDAY<br>June 28                                                                                                | SATURDAY<br>June 29                                                                                          |
|----------------|------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| 8:00<br>a. m.  | REGISTRATION                                                                                               |                                                                                                   |                                                                                                                              |                                                                                                                                                 |                                                                                                                  |                                                                                                              |
| 9:00<br>a. m.  | PEDIATRICS<br><br>"Coeliac Disease<br>and Allied<br>Conditions"<br><br>DR. DARROW                          | PEDIATRICS<br><br>"Pyurias (including<br>Renal Rickets)"<br><br>DR. DARROW                        | PEDIATRICS<br><br>"Treatment of<br>Infantile Diarrhea"<br><br>DR. DARROW                                                     | GYNECOLOGY<br><br>"Treatment,<br>Medical and Surgical,<br>of Chronic Pelvic<br>Inflammation"<br><br>DR. MICHAUX                                 | GYNECOLOGY<br><br>"Discussion of<br>Endometriosis and<br>Its Possible<br>Prevention"<br><br>DR. MICHAUX          | SURGERY<br><br>"The Management<br>of Ulcer<br>Complications"<br><br>DR. McNEALY                              |
| 10:00<br>a. m. | VENEREAL<br>DISEASES<br><br>"Syphilis, the<br>Practitioner, and<br>the Public<br>Health"<br><br>DR. PADGET | VENEREAL<br>DISEASES<br><br>"Diagnosis and<br>Treatment of<br>Late<br>Syphilis"<br><br>DR. PADGET | OBSTETRICS<br><br>"Indications<br>for Use of<br>Forceps in<br>Cesarean Section"<br><br>DR. PRIDE                             | OBSTETRICS<br><br>"Acidosis in<br>Pregnancy and<br>Labor"<br><br>DR. PRIDE                                                                      | OBSTETRICS<br><br>"Safe and<br>Effective<br>Analgesia<br>in Labor"<br><br>DR. PRIDE                              | ORTHOPEDIC<br>SURGERY<br><br>"Bone Tumors"<br><br>DR. CAMPBELL                                               |
| 11:00<br>a. m. | RECESS                                                                                                     | RECESS                                                                                            | RECESS                                                                                                                       | RECESS                                                                                                                                          | RECESS                                                                                                           | SURGERY                                                                                                      |
| 11:30<br>a. m. | MEDICINE<br><br>"Modern<br>Conception of<br>Hypertension"<br><br>DR. THOMAS                                | MEDICINE<br><br>"The Heart in<br>Hyperthyroidism"<br><br>DR. THOMAS                               | MEDICINE<br><br>"Diseases of<br>the Lymph<br>Glands"<br><br>DR. THOMAS                                                       | SURGERY<br><br>"Present Status<br>of Appendicitis"<br><br>DR. McNEALY                                                                           | SURGERY<br><br>"Pre- and<br>Postoperative<br>Management of<br>Surgical Cases"<br><br>DR. McNEALY                 | "Congenital<br>Tumors<br>of the<br>Neck"<br><br>DR. McNEALY                                                  |
| 12:30<br>p. m. | LUNCH                                                                                                      | LUNCH                                                                                             | LUNCH                                                                                                                        | LUNCH                                                                                                                                           | LUNCH                                                                                                            |                                                                                                              |
| 2:00<br>p. m.  | VENEREAL<br>DISEASES<br><br>"The Diagnosis<br>and Treatment<br>of Early<br>Syphilis"<br><br>DR. PADGET     | OBSTETRICS<br><br>"Diagnosis of<br>Early<br>Pregnancy<br>and Prenatal<br>Care"<br><br>DR. PRIDE   | OBSTETRICS<br><br>"Long Labors:<br>Their Cause<br>and<br>Correction"<br><br>DR. PRIDE                                        | OBSTETRICS<br><br>"Hemorrhage<br>Antepartum and<br>Post Partum"<br><br>DR. PRIDE                                                                | ORTHOPEDIC<br>SURGERY<br><br>"Diseases of<br>the Hip<br>in<br>Children"<br><br>DR. CAMPBELL                      | 12:00 noon<br><br>ORTHOPEDIC<br>SURGERY<br><br>"Treatment of<br>Fractures of<br>the Hip"<br><br>DR. CAMPBELL |
| 3:00<br>p. m.  | RECESS                                                                                                     | RECESS                                                                                            | RECESS                                                                                                                       | RECESS                                                                                                                                          | RECESS                                                                                                           |                                                                                                              |
| 3:15<br>p. m.  | MEDICINE<br><br>"Treatment of<br>Hypertension"<br><br>DR. THOMAS                                           | MEDICINE<br><br>"Treatment of<br>Diabetic<br>Complications"<br><br>DR. THOMAS                     | MEDICINE<br><br>"The Value of<br>Psychiatry in<br>Internal Medicine"<br><br>DR. THOMAS                                       | GYNECOLOGY<br><br>"Displacements<br>of the<br>Pelvic Organs<br>with Relation to<br>Posture and<br>Structural<br>Development"<br><br>DR. MICHAUX | GYNECOLOGY<br><br>"Early Diagnosis<br>and Treatment of<br>Malignancy of the<br>Pelvic Organs"<br><br>DR. MICHAUX |                                                                                                              |
| 4:15<br>p. m.  | RECESS                                                                                                     | RECESS                                                                                            | RECESS                                                                                                                       | RECESS                                                                                                                                          | RECESS                                                                                                           |                                                                                                              |
| 4:30<br>p. m.  | PEDIATRICS<br><br>"Renal Conditions<br>of Childhood"<br><br>DR. DARROW                                     | PEDIATRICS<br><br>"Dehydration"<br><br>DR. DARROW                                                 | GYNECOLOGY<br><br>"Diseases of<br>the Cervix and<br>Alterations of the<br>Secretions of<br>Vaginal Tract"<br><br>DR. MICHAUX | SURGERY<br><br>"The Use of<br>Hemo-coagulation<br>Factors with Special<br>Reference to<br>Vitamin K"<br><br>DR. McNEALY                         | SURGERY<br><br>"Surgery of<br>the Thyroid<br>Gland"<br><br>DR. McNEALY                                           |                                                                                                              |
| 7:00<br>p. m.  |                                                                                                            | Medicine Dinner:<br>Round-Table,<br>Dr. Thomas                                                    | Specialties Dinners                                                                                                          |                                                                                                                                                 | Surgery Dinner:<br>Round-Table,<br>Dr. McNealy                                                                   |                                                                                                              |
| 7:30<br>p. m.  | Joint Clinic in<br>Venereal Diseases<br>Dr. Padget<br>and<br>Dr. Wm. Perry<br>Duval County<br>Hospital     |                                                                                                   |                                                                                                                              |                                                                                                                                                 |                                                                                                                  |                                                                                                              |

## SHORT COURSE ANNOUNCEMENTS

## MEETING PLACES

All regular sessions of the Short Course will be held at the George Washington Hotel, Jacksonville, which is entirely airconditioned and is offering attractive rates to physicians attending the Course and their families. Two special clinics in Venereal Diseases will be held at Brewster Hospital and a joint clinic in Venereal Diseases will be held at Duval County Hospital. Times for these clinics will be found on the official program.

## REGISTRATION

Registration will begin at 8 o'clock Monday morning, June 24, at the headquarters hotel. Anyone wishing to register earlier may do so through Dr. G. C. Tillman, Gainesville. A registration fee of \$5.00 will be charged.

## HOTELS

Other hotels offering special rates for the duration of the Course are the Mayflower, the Roosevelt, the Seminole, the Windle, and the Windsor.

## CLINICAL MATERIAL TO BE AVAILABLE

For the first time since the establishment of the annual Graduate Short Course, clinical material is to be presented in connection with the lectures. This innovation is possible through the cooperation of the Duval County Hospital and the ambulance companies of Jacksonville.

## ROUND-TABLE FOR DINNER HOURS

A special feature of the 1940 Short Course will be round-table discussions at dinner three evenings during the week. Each discussion will be conducted by a member of the faculty, who will take up questions concerning his specialty. These questions may be turned in at the registration desk up to noon the day of the dinner. Arrangements for attending the dinners may also be made at the registration desk.

The dates for the dinners are as follows:

|                             |                                              |
|-----------------------------|----------------------------------------------|
| Tuesday, June 25, 7 p. m.   | Medicine.                                    |
| Wednesday, June 26, 7 p. m. | Pediatrics, Obstetrics, Urology, Gynecology. |
| Friday, June 28, 7 p. m.    | Surgery, Orthopedic Surgery.                 |

Additional information may be secured from the following Jacksonville doctors who are in charge of arranging the dinners: Medi-

cine, Dr. Louie Limbaugh; Pediatrics, Dr. Thomas E. Buckman; Obstetrics, Dr. S. R. Norris; Urology, Dr. E. T. Sellers; Gynecology, Dr. Ferdinand Richards; Surgery, Dr. Frederick J. Waas; Orthopedic Surgery, Dr. Frank Fort.

## BIRTHS AND DEATHS

## BIRTHS

Dr. and Mrs. Sidney G. Kennedy, Jr., of Pensacola, announce the birth of a son, William Ennis, on February 27.

## DEATHS

Dr. Robert Y. H. Thomas of Jacksonville died April 14, following an illness of six months.

\* \* \*

Dr. David A. Mills of Zephyrhills died April 23, 1940.

\* \* \*

Dr. George H. Day of Sarasota died on March 26, 1940.

## STATE NEWS ITEMS

\* \* \*

The Florida East Coast Medical Association will hold its annual meeting in Miami late in October or early in November. The Miami delegation will spare no effort to make this an outstanding meeting.

Requests for space on the program should be made early to Dr. E. C. Swift, Chairman of the Program Committee, 614 Greenleaf Building, Jacksonville. It is not necessary to send a copy of the proposed paper—simply furnish a synopsis and the names of two discussors.

\* \* \*

A printed, paper-backed copy of the 1900 Transactions of the Florida Medical Association was secured through the State Medical Society of Pennsylvania recently.

Copies of annual transactions are still missing for the years 1874 to 1894, inclusive; the year 1899; and the year 1901. There are also two Journals of the Florida Medical Association missing: the one for June, 1915, and the one for May, 1916. An effort has been made over a long period of years to complete the Association's records of transactions and Journals. It is hoped that the other missing records will eventually find their way to the Association's home office.



Dr. Norman W. McLeod, Jr., announces the opening of an office in the Ingraham Building, Miami, for the practice of obstetrics and gynecology.

\* \* \*

The following Florida doctors attended the meeting of the Southeastern Surgical Congress in Birmingham, March 11 to 13: W. D. Sugg, Bradenton; J. S. Turberville, Century; J. Ralston Wells, Daytona Beach; T. A. Snow, Gainesville; T. Z. Cason and E. C. Watt, Jacksonville; A. H. Lisenby, Panama City; C. C. Webb, Pensacola; V. H. Ragsdale, Pierce; and J. H. Pound, Tallahassee.

\* \* \*

Dr. William W. Kirk of Jacksonville has been commissioned a lieutenant-commander in the Naval Reserve of the United States Army, effective February 23.

\* \* \*

Dr. R. D. Ferguson of Ocala was recently named chairman of the newly formed Marion County Public Health Committee. This Committee is dedicated to promoting the establishment of a full-time county health unit.

\* \* \*

Dr. Edward Jelks of Jacksonville was guest speaker at the fourth annual banquet of Alpha Epsilon Delta, honorary pre-medical fraternity, University of Florida, on the evening of April 4.

\* \* \*

Dr. Ralph E. Russell, Ocala's medical examiner for the Civil Aeronautics Authority, took a postgraduate course at the George Washington University in April in aviation ophthalmology.

\* \* \*

Many members of the Hillsborough County Medical Society are lending their active support to the cancer control drive sponsored by the Women's Field Army. The following doctors have appeared on civic programs where "Cancer Prevention" was the topic under consideration:

Dr. H. O. Brown of Tampa addressed the local Civitan Club; Dr. A. M. C. Jobson of Tampa, the local Lions Club; and Dr. C. A. Andrews of Tampa the local Rotary Club.

\* \* \*

Friends of Dr. Joseph J. Ruskin of Tampa will regret to learn of the death of his mother whose home was in Wilkes-Barre, Pa.

Dr. Edward Annis of Tallahassee was principal speaker at a meeting of the Tallahassee Woman's Club on April 11. His subject was "Cancer Control."

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THREE SPECIALISTS are desired as associates in Buena Vista Clinic, 85 N. E. 36th Street, Miami: eye, ear, nose and throat; pediatrician; and doctor of dental surgery. Anyone interested is requested to direct a communication to the above address.

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### ROBERT Y. H. THOMAS

Dr. Robert Y. H. Thomas of Jacksonville died at his home on April 14, following an illness of six months.

A native of Gainesville, Florida, Doctor Thomas received his preliminary education at the public schools and at the East Florida Seminary (now the University of Florida) of that city. He then attended the South Carolina Medical College from which he received the degree of Doctor of Medicine in 1904.

Immediately following his graduation, he opened an office in Jacksonville for the practice of medicine but a year later gave up his practice to become assistant superintendent of the Duval County Hospital. Shortly thereafter he was elected superintendent and served in that office for a number of years. Later he resigned to devote all of his time to the private practice of surgery.

Doctor Thomas came from a family of medical men, his father being an outstanding physician of Gainesville and Cedar Keys. He was a member of the Duval County Medical Society, the Florida Medical Association, the Southern Medical Association, and the American Medical Association. For many years he was active in Ionic Lodge, No. 101, Free and Accepted Masons, and a member of the Springfield Methodist Episcopal Church.

Doctor Thomas was married to Miss Selma Johnson Hilliard of Jacksonville in 1906. She died April 10, 1924.

Survivors are his son, Dr. Robert Y. H. Thomas, III, of Jacksonville; a stepdaughter, Mrs. J. V. Schleicher of Jacksonville; two sisters, Mrs. Julia P. Lynch of Jacksonville, and Mrs. W. L. Floyd of Gainesville.

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MATHEW W. SPEARMAN

Dr. Mathew W. Spearman of Lake City died March 1, at the age of 59 years, following an illness of several months.

Doctor Spearman was born in Shady Dale, Georgia, the son of M. W. and Julia Geiger Spearman. He received his medical degree from the Atlanta School of Medicine (which later became Emory University School of Medicine) in 1912. He practiced medicine in Chickamauga, Georgia, for sixteen years prior to coming to Lake City six years ago.

Surviving are his widow, Irene Smithson Spearman, and three children, Betty, Jane, and George; also three brothers and one sister.

Though his residence in Florida had been comparatively short, Doctor Spearman had won a wide circle of friends, both within and outside of his profession. He was a member of the Columbia County Medical Society, the Florida Medical Association and the American Medical Association.

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## GEORGE H. DAY

Dr. George H. Day, 62, died at his home in Sarasota, on March 26, following an extended illness.

Born in New Albany, Ind., February 16, 1879, he attended Hanover College and graduated with a doctor of medicine degree from the University of Louisville, at Louisville, Ky.

Doctor Day practiced medicine in Louisville for 20 years before ill health caused him to move to Sarasota where he built his home in 1926. Greatly improved in health, he moved to Miami in 1928, and practiced medicine there until 1938 when he returned to Sarasota. He has been confined to his home for the past two years.

Doctor Day was a Spanish war veteran, a member of the American Medical Association, the Florida Medical Association, and the Dade County Medical Society, a former Mason and Elk, and served as a major in the World War.

He is survived by his widow, Mrs. Katherine C. Day; one son, George H. Day, Jr., both of Sarasota; one sister, Mrs. Nell Day Kennedy of New Albany, Ind., and one brother, C. C. Day, of Aberdeen, Miss.

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## COMPONENT COUNTY SOCIETIES

## ALACHUA COUNTY MEDICAL SOCIETY

The regular meeting of the Alachua County Medical Society was held at the University of Florida Infirmary on April 10 with Dr. Edwin H. Andrews presiding. Doctor Andrews expressed the appreciation of the Society to Dr. G. C. Tillman for arranging this meeting and for the delightful entertainment provided.

Dr. Louis M. Orr of Orlando conducted an informal discussion on questions presented by those in attendance. Doctor Andrews brought up the question of the incidence of urinary calculi and the reasons for their formation; Doctor Tillman asked for information in regard to water and mineral balance studies; Doctor Cason of Jacksonville asked why neoprontosil is used in place of sulfanilamide; Doctor Shaw of Jacksonville asked for Doctor Orr's experience in the treatment of kidney tumors. The subjects were fully discussed by Doctor Orr.

\* \* \*

## DADE COUNTY MEDICAL SOCIETY

At the meeting of the Dade County Medical Society held on the evening of April 3 in the Sunshine Room of the Ingraham Building, Miami, two papers constituted the scientific program, as follows:

"Surgical Abnormalities of the Uterus" by John W. Snyder; discussed by Thomas O. Otto and Randolph Perdue.

"Abdominal Pregnancies" by Walter C. Jones, discussed by M. C. Wilson and Edward Fox.

\* \* \*

DE SOTO-HARDEE-HIGHLANDS-CHARLOTTE-  
GLADES COUNTY MEDICAL SOCIETY

When a society which draws members from ten cities scattered over five counties reports 100% of its State Association dues paid, it means either that somebody has been hard at work or that the society is an alert, enthusiastic one. Possibly both of these conditions apply in the DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society, the latest component group to join the Honor Roll. Officers of the society, to whom a great deal of credit for this achievement must go, are: H. E. Boorum, Sebring, president; M. A. Collier, Wauchula, vice-president; and H. V. Weems, Sebring, secretary-treasurer.



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## DUVAL COUNTY MEDICAL SOCIETY

The regular meeting of the Duval County Medical Society was held on the evening of April 2 in the Library of the State Board of Health Building, Jacksonville. The following program was enjoyed:

"X-ray Treatment of Cancer; Metastases, and Recurrence" (with lantern slides and colored motion pictures)—Dr. H. B. McEuen.  
"Advances in Diagnostic Roentgenology"—T. H. Lipscomb.

\* \* \*

## ESCAMBIA COUNTY MEDICAL SOCIETY

On the evening of April 9 the members of the Escambia County Medical Society were hosts to members of the profession from northwest Florida and south Alabama, as well as medical officers of the Army and Navy stationed in Pensacola. Dr. Alton Ochsner of New Orleans, guest speaker, presented a paper on "Peripheral Vascular Disease."

\* \* \*

## FRANKLIN-GULF COUNTY MEDICAL SOCIETY

Dr. A. E. Conter of Apalachicola was host to the members of the Franklin-Gulf County Medical Society at a meeting held on the evening of April 17. A chicken dinner was served at the Gibson Hotel, following which a scientific session and a business meeting were held. A very interesting and educational motion picture on obstetrics was enjoyed not only by the members of the society but by the nurses of the district who had been invited to attend this feature of the program.

\* \* \*

## LAKE COUNTY MEDICAL SOCIETY

Dr. Don C. Robertson of Orlando was guest speaker at a meeting of the Lake County Medical Society held on April 4. His subject was "A Review of 200 Cases of Herniae."

\* \* \*

## LEE COUNTY MEDICAL SOCIETY

The Lee County Medical Society has 100% of its State Association dues paid for the current year. Officers of this society are: A. S. Byle, Ft. Myers, president; Harry L. Allan, Ft. Myers, vice-president; and Fred D. Bartleson, Ft. Myers, secretary-treasurer.

LEON-GADSDEN-LIBERTY-WAKULLA-  
JEFFERSON COUNTY MEDICAL SOCIETY

The quarterly meeting of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society was held on the afternoon of April 18 at the Wakulla Springs Hotel, Wakulla Springs. The following scientific program was presented:

"Sciatica" (with lantern slides) — Exum Walker, Atlanta.  
"Intrathoracic Goiter" (with lantern slides) — Claude Anderson, Orlando.  
"Cesarean Section" (with motion pictures) — J. K. Johnston, Tallahassee.  
"The Differential Diagnosis of Chest Pain" — Edson Andrews, Tallahassee.

\* \* \*

## PALM BEACH COUNTY MEDICAL SOCIETY

The Palm Beach County Medical Society, which is continually growing in size and strength, is on the Honor Roll of 100% paid societies. Heading this organization this year are: James H. Pittman, president; W. O. Arnold, vice-president; C. J. Derrick, secretary; and Frederick K. Herpel, treasurer.

\* \* \*

PASCO-HERNANDO-CITRUS COUNTY  
MEDICAL SOCIETY

Dr. W. Wardlaw Jones entertained the Pasco-Hernando-Citrus County Medical Society at Dade City, April 11. A chicken dinner was enjoyed at the Grey Moss Inn, followed by the scientific meeting in Doctor Jones' office.

Interesting case reports were presented by those in attendance. Dr. R. D. Sistrunk invited the Society to meet with him in Dade City on May 9.

Present at this meeting were: Drs. J. T. Bradshaw, Edwin H. Brown, G. R. Creekmore, L. H. Dame, George A. Dame, S. C. Harvard, P. J. Hudson, W. W. Jones, R. D. Sistrunk, and W. H. Walters.

\* \* \*

## PINELLAS COUNTY MEDICAL SOCIETY

A joint dinner meeting of the St. Petersburg Bar Association and the Pinellas County Medical Society was held at the Yacht Club on the evening of April 3. Dr. H. Mason Smith of Tampa, principal speaker, presented a paper on "Expert Medical Testimony."





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\*"Treatment of Acute Anterior Urethritis with Silver Picrate," Knight and Shelanski, AMERICAN JOURNAL  
OF SYPHILIS, GONORRHEA AND VENEREAL DISEASES, Vol. 23, No. 2, pages 201-206, March, 1939.

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## ABSTRACT DEPARTMENT

*Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.*

**Iron Deficiency Anemia in Children, ABBOTT, O. D., and AHMANN, C. F., Gainesville, Am. J. Dis. Child. 58: 811-816 (October), 1939.**

Studies of hemoglobin values in two groups of children were made. The first group was composed of children from grades 1 to 3 of 14 rural schools; the second those in nursery school (ages from 3 to 5) whose parents were on relief. After these evaluations, 200 children from Group I with hemoglobin values from 35 to 70 per cent and 40 of those from Group II with values from 40 to 60 per cent, were selected for treatment. Treatment of those in the first group consisted of 15 grains of iron and ammonium citrate after meals. Those in Group II were given no iron but diets high in iron content.

Those to whom iron, as such, was given over a period of 42 days showed a rapid regeneration of hemoglobin. Those treated by diet alone showed some improvement but with none of the rapidity that characterized those given iron directly.

An interesting observation was that though many of these children were infected with hookworm, the administration of iron raised the hemoglobin levels and mitigated many of the symptoms ordinarily associated with uncinariasis.

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**Dynamic Ileus (Report of Four Cases), MELVILLE, E. J., St. Petersburg, Clin. Med. & Surg. 45: 61-63 (February), 1938.**

Four cases of dynamic ileus, in which all patients recovered, are described and discussed. Treatment consisted of routine gastric lavage every 6 hours, followed each time by the installation of 4 oz. of castor oil, pituitrin, dextrose intravenously and by rectal drip, and opiates were used as adjunctive therapy.

The author warns against the classification of all obstructions as surgical.



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**Respiratory Infections: Incidence and Clinical Course as Observed in a Florida Pediatrics Practice, QUILLIAN, WARREN W., Coral Gables, J. Pediat. 15: 704-709 (November), 1939.**

A large percentage of the pediatric practice in Florida as elsewhere is composed of the respiratory infections or their sequelae. This, in the author's series which was from the Miami area, reaches some 47 per cent. It is suggested that this may be influenced by the seasonal influx of winter visitors.

The duration of these infections approximates that found elsewhere but virulence is less marked and complications less frequent though the latter may be severe in intensity.

Conservative medical management of these conditions is advocated.

**Psittacosis, HAHN, THEODORE F., JR., DeLand, Cyclopedia of Med. 10: 637, 1940.**

This bibliography concerns psittacosis, an acute infectious disease resulting from contact with parrots or laboratory animals suffering from so-called parrot fever. Psittacosis was first described in 1879. About 50 to 100 cases were described until 1930 when it suddenly became pandemic. Since this time it has remained endemic wherever there are parrots or parrot breeding centers.

The disease is severe with pneumonic and neurologic centers and has a fairly high mortality rate. Treatment is only symptomatic. Strict public health measures are enforced to regulate the sale and breeding of parrots in this country.

The disease is not necessarily limited to parrots because psittacosis has been described in many different birds and laboratory animals.

**Preputial Adhesions in the Circumcised Penis, MARKS, M. B., Miami Beach, Arch. Pediat. 56: 458-459 (July), 1939.**

The author emphasizes the importance of instructions to the mother regarding care of the foreskin in circumcised infants in order to prevent the formation of adhesions between the mucous membrane and the glans penis. This should consist of irrigation of the sulcus at the time of the bath and subsequent application of sterile vaseline.

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## ADVERTISERS' NOTES

### SEABOARD OFFERS IMPROVED SERVICE

Members of the Florida medical profession who are heading north in June to attend the American Medical Association meeting to be held in New York City, June 10 to 14, also to visit the World's Fair of 1940, and visit northern resorts, will be interested in learning that the Seaboard Railway is offering new and faster service between both coasts of our State, and the central portion, to the North.

The Seaboard is a Florida pioneer having been the first railroad to provide streamline north-south rail service with its "Silver Meteor" and first to introduce the new giant Diesel-electric locomotives which pull the "Silver Meteor" and "Southern States Special." As for the new Seaboard service which went into effect April 28, the popular "Southern States Special" will make the Florida-New York run three hours faster than during the past winter.

The fine Diesel-electric powered limited has sleeping cars and reclining seat coaches and leaves Miami daily at 10:30 A. M., St. Petersburg 12:30 P. M., Tampa 2:30 P. M., and Jacksonville 7:40 P. M., arriving New York the next afternoon at 4:15 P. M. The "Silver Meteor," America's newest and smartest streamlined de luxe coach train leaves Miami 10:00 A. M., West Palm Beach 11:21 A. M., and Jacksonville 4:45 P. M., arriving New York 10:55 A. M. the following morning.

The Seaboard Railway offers this year the finest fleet of most modern trains and lowest possible railroad fares from Florida to all points North.

Those who contemplate attending the American Medical Association meeting in New York in June, please get in touch with your local Seaboard Ticket Agent and make your reservations early. Also, please note our ad which is being carried in this, the May issue of the Florida Medical Journal, and for any further information consult your nearest Seaboard Agent, or write Mr. W. J. Kenealy, General Passenger Agent, Seaboard Railway, in Jacksonville, Florida. See page 543 of this Journal.

### STEREOSCOPIC PHOTOGRAPHS

Actual stereoscopic photographs of diseased eyes, the first ever published, have been made available to assist eye specialists in the diagnosis and study of diseases of the fundus (background of the eye), Dr. J. F. Neumueller, director of American Optical Company's Bureau of Visual Science, announced recently.

The collection is made up of 50 selected photographs which, according to the scientist, have amazing depth perception and when dropped into an ordinary stereoscope have such perspective that disease conditions are brought out clearly. The pictures were selected by Dr. Louis Bothman, noted eye authority and professor at the University of Chicago Medical School.

Each photograph, Dr. Neumueller said, carries an explanation of the condition being studied and a clear summary of diagnostic conditions. These outlines, he added, identify at once the essential points shown in the photographs and consequently are dependable guides to a sound diagnosis of eye conditions.

### VITAMIN ADVERTISING AND

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### PERNICIOUS ANEMIA—TREATMENT

So much emphasis has been placed on the blood picture of the pernicious anemia patient that the rather characteristic body build of these individuals is often overlooked. Their tendency toward early graying of hair was recently pointed out (J. Indiana M. A. 32: 607, 1939) and the fact that they have a higher percentage of light hair and light-colored eyes than a normal control group. They tend to be long-eared persons, often with square and prominent jaws.

The maintenance dose of liver extract must be determined individually for each patient. It is usually one U. S. P. unit a day or the equivalent amount given at longer intervals. From two to five units are needed daily if the red-blood count is lower than three million per cubic millimeter. Neurological complications need not be feared if dosage is adequate to keep the red-blood-cell count around five million per cubic millimeter.

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**OBSTETRICS**—Two Weeks' Intensive Course starting June 3rd. Informal Course every week.

**OTOLARYNGOLOGY**—Two Weeks' Intensive Course starting September 9th. Informal and Personal Courses every week.

**OPHTHALMOLOGY**—Two Weeks' Intensive Course starting September 23rd. Informal Course every week.

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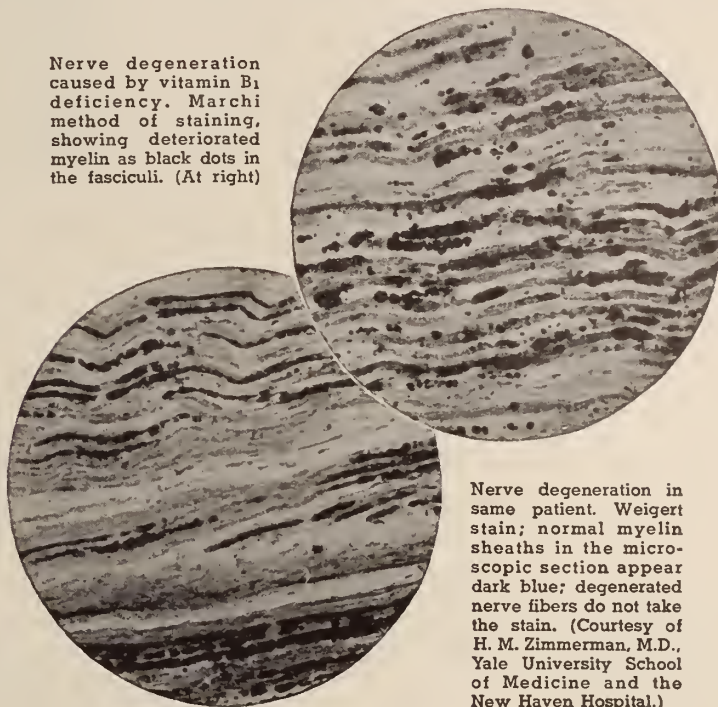
## STUDIES IN THE AVITAMINOSES



This page is the fifth of a series on vitamin deficiencies presented by the research division of The Upjohn Company because of the profession's widespread interest in the subject. A full color, two-page insert on the same subject appears in the April 27 issue of The Journal of the American Medical Association.

ONE of the specific lesions resulting from thiamin deprivation consists of degenerative changes in the myelin sheaths of nerve fibers. In peripheral nerves, the myelin breaks down into small globules and finally disappears, and the axis-cylinder undergoes atrophy and fragmentation. Degeneration has been described also in the spinal cord, especially in the posterior columns and anterior and posterior nerve roots, and in the posterior spinal ganglions and the anterior horn cells.

Nerve degeneration caused by vitamin B<sub>1</sub> deficiency. Marchi method of staining, showing deteriorated myelin as black dots in the fasciculi. (At right)



Nerve degeneration in same patient. Weigert stain; normal myelin sheaths in the microscopic section appear dark blue; degenerated nerve fibers do not take the stain. (Courtesy of H. M. Zimmerman, M.D., Yale University School of Medicine and the New Haven Hospital.)

## The Neurologic Manifestations of Vitamin B<sub>1</sub> Deficiency



Above, peripheral neuritis of nutritional etiology; note limited dorsiflexion. At right, improvement in dorsiflexion after two and one-half weeks of thiamin chloride therapy. (Courtesy of Henry Field, Jr., M.D., University of Michigan.)

THE early manifestations of vitamin B<sub>1</sub> deficiency affecting peripheral nerves are pain and burning along the involved sensory neurons and impairment of motor nerve function. If the deficiency remains uncorrected, fragmentation of the axis-cylinders of motor nerves follows, leading to further loss of function and atrophy of the innervated muscles. Administration of thiamin chloride over a prolonged period slowly produces regeneration of the involved neurons. If complete degeneration of cells and axis-cylinders in the central nervous system has occurred, regeneration cannot take place.



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## THE ANNUAL CONVENTION

The Fourteenth Annual Meeting of the Woman's Auxiliary to the Florida State Medical Association, was held in Tampa, April 29, 30 and May 1, with headquarters at the Tampa Terrace Hotel.

Members of the Woman's Auxiliary were delightfully entertained by the wives of physicians belonging to the Hillsborough County Medical Society. A motorcade to the Gulf beaches followed by a cocktail party and dinner at the Tampa Yacht and Country Club where all physicians' wives were guests, marked the opening activities of the convention.

At the business session of the Auxiliary, the following officers were elected: Mrs. Gordon H. Ira, Jacksonville, president; Mrs. J. W. McMurray, Ft. Lauderdale, first vice-president; Mrs. F. W. Krueger, Jacksonville, second vice-president; Mrs. Leroy H. Oetjen, Leesburg, recording secretary; Mrs. Clayton E. Royce, Jacksonville, corresponding secretary; Mrs. M. J. Flipse, Miami, historian; and Mrs. J. Ralston Wells, Daytona Beach, parliamentarian.

Following the election of officers, Mrs. Rollo Packard, Chicago, president of the National Auxiliary to the American Medical Association, presented Mrs. L. C. Ingram, Orlando, retiring president of the Florida State Medical Auxiliary, with a past president's pin in a most impressive manner, calling attention to the outstanding services rendered by Mrs.



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A Spanish luncheon at the Columbia restaurant was the highlight of the convention. Castanets with greetings and a welcome to the Medical Auxiliary, were used as favors to mark the places. Other favors added pleasure and convenience to those attending the luncheon. Mrs. Rollo Packard, guest speaker, delighted members with an interesting and inspiring message emphasizing the high ideals and noble objectives towards which the organization is striving. She also gave her impressions of "Florida, the land of sunshine and flowers" and expressed the hope that she would again have the pleasure of visiting this beautiful state.

A cocktail party and dinner for both the doctors and their wives in the evening at the Palm Room of the Tampa Terrace Hotel was a great success. A county presidents' breakfast on the last day of the convention, concluded the festivities.

#### DADE COUNTY AUXILIARY

Mrs. Hubert A. Barge was elected president of Dade County Medical Society auxiliary at a meeting at Barcelona Inn April 8. Annual reports were given and installation followed elections.

Other officers are Mrs. Jack A. McKenzie, first vice-president; Mrs. C. A. Scarborough, second vice-president; Mrs. Colquitt Pearson, recording secretary; Mrs. C. C. Adams, corresponding secretary; Mrs. James L. Anderson, treasurer; Mrs. R. O. Lyell was installing officer.

Delegates and alternates for the state convention in Tampa April 29-30 included Mrs. Carl Dunaway, Mrs. William J. Barge, and Mrs. Lyell, delegates; Mrs. W. A. Haggard, Mrs. W. T. Lanier and Mrs. C. C. Adams, alternates.

Chairmen appointed thus far include Mrs. Pearson, health; Mrs. James McClamroch, hospitality; Mrs. Herman Boughton and Mrs. William J. Barge, social service; Mrs. Haggard, program; Mrs. H. A. Reese, historian; Mrs. W. T. Lanier, courtesy; Mrs. A. W. Wood and Mrs. A. G. Brown, membership; Mrs. Thomas L. Roberts, public relations; Mrs. Dunaway, library; Mrs. P. J. Monson, Hygeia.

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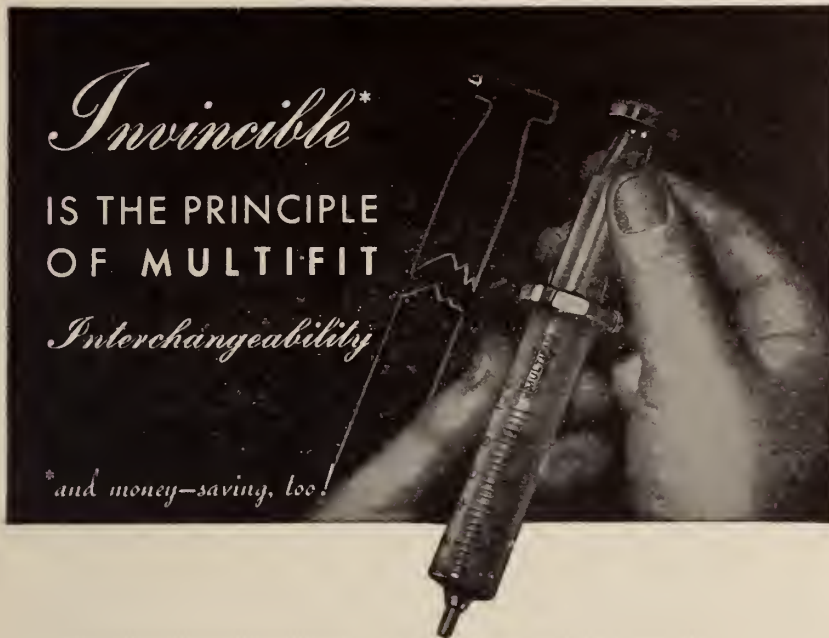
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## COMPONENT SOCIETIES BY DISTRICTS

| COUNTY SOCIETIES                                  | PRESIDENT                                                           | SECRETARY                                                          | MEETING DATE                                                           | MEMBERS |      | COUNCILORS AND DATES OF MEDICAL DISTRICT MEETINGS        |
|---------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------|------------------------------------------------------------------------|---------|------|----------------------------------------------------------|
|                                                   |                                                                     |                                                                    |                                                                        | Total   | Paid |                                                          |
| Bay                                               | Amsie H. Lisenby, M.D.<br>Panama City                               | William C. Roberts, M.D.<br>Panama City                            |                                                                        | 11      | 9    | A-1-'41<br>W. C. Roberts, M.D.<br>Panama City            |
| Escambia<br>*Santa Rosa                           | Sidney G. Kennedy, M.D.<br>511 American Nat. Bk. Bldg.<br>Pensacola | W. E. Tugwell, M.D.<br>Box 860<br>Pensacola                        | 2nd Tuesday<br>8:00 P. M.                                              | 44      | 35   |                                                          |
| Walton-Okaloosa                                   | A. G. Williams, M.D.<br>Lakewood                                    | R. B. Spires, M.D.<br>DeFuniak Springs                             | 3rd Thursday<br>8:00 P. M.                                             | 6       | 100% | Northwest District (A)<br>Pensacola<br>Oct. 5, 1940      |
| Washington-Holmes                                 | R. H. Segrest, M.D.<br>Bonifay                                      | L. H. Paul, M.D.<br>Bonifay                                        |                                                                        | 8       | 5    |                                                          |
| Franklin-Gulf                                     | Thos. Meriwether, M.D.<br>Wewahitchka                               | J. R. Norton, M.D.<br>Port St. Joe                                 | 3rd Thursday                                                           | 7       | 100% | A-2-'41<br>B. A. Wilkinson, M.D.<br>Tallahassee          |
| Jackson<br>*Calhoun                               | W. R. Wandek, M.D.<br>Marianna                                      | R. N. Joyner, M.D.<br>Marianna                                     | 2nd Tuesday<br>7:30 P. M.                                              | 12      | 8    |                                                          |
| Leon-Gadsden-Liberty-<br>Wakulla-Jefferson        | Francis T. Holland, M.D.<br>208 Midyette-Moor Bldg.<br>Tallahassee  | B. A. Wilkinson, M.D.<br>Telephone Bldg.<br>Tallahassee            | Quarterly<br>3:00 P. M.                                                | 40      | 38   |                                                          |
| Columbia<br>*Baker, Hamilton                      | L. J. Arnold, Jr., M.D.<br>Lake City                                | Harry S. Howell, M.D.<br>Blanche Hotel Annex<br>Lake City          | 1st Monday<br>7:30 P. M.                                               | 14      | 8    | B-3-'41<br>W. S. Nichols, M.D.<br>Lake City              |
| Madison-Suwannee                                  | J. M. Price, M.D.<br>Live Oak                                       | I. H. Black, M.D.<br>Live Oak                                      |                                                                        | 9       | 5    |                                                          |
| Taylor<br>*Dixie, Lafayette                       | J. L. Weeks, M.D.<br>Perry                                          | John C. Ellis, M.D.<br>Perry                                       | Last Friday<br>8:00 P. M.                                              | 7       | 6    |                                                          |
| Alachua<br>*Bradford, Gilchrist<br>Union          | Edwin H. Andrews, M.D.<br>134 N. Pleasant St.<br>Gainesville        | J. Maxey Dell, Jr., M.D.<br>333 W. Main St., S.<br>Gainesville     | 2nd Wednesday<br>7:30 P. M.                                            | 30      | 21   | B-4-'41<br>J. L. Summerlin, M.D.<br>Gainesville          |
| Marion<br>*Levy                                   | Henry C. Dozier, M.D.<br>9 No. Magnolia St.<br>Ocala                | R. C. Cumming, M.D.<br>Commercial Bank Bldg.<br>Ocala              | 3rd Thursday<br>12:30 P. M.                                            | 24      | 100% |                                                          |
| Pasco-Hernando-<br>Citrus                         | Wm. H. Walters, Jr., M.D.<br>Lacoochee                              | G. R. Creekmore, M.D.<br>Brookmore                                 | 2nd Thursday<br>7:00 P. M.                                             | 14      | 100% | North Central District (B)<br>Lake City<br>Oct. 4, 1940  |
| Duval<br>*Clay, Nassau                            | Chas. B. Mabry, M.D.<br>439 St. James Bldg.<br>Jacksonville         | Lauren M. Sompayrac, M.D.<br>459 St. James Bldg.<br>Jacksonville   | 1st Tuesday<br>8:15 P. M.                                              | 180     | 179  | C-5-'41<br>B. B. McIver, M.D.<br>Jacksonville            |
| St. Johns                                         | Donald T. Rankin, M.D.<br>East Coast Hospital<br>St. Augustine      | Vernon A. Lockwood, M.D.<br>East Coast Hospital<br>St. Augustine   | 3rd Tuesday<br>8:30 P. M.                                              | 10      | 9    | N. E. District (C)<br>Daytona Beach<br>Oct. 3, 1940      |
| Putnam                                            | G. M. Zeagler, M.D.<br>Glendale Hospital<br>Palatka                 | Bernard E. Kane, M.D.<br>Crescent City                             | 2nd Tuesday in<br>Feb., April, June,<br>Aug., Oct., Dec.<br>7:00 P. M. | 11      | 6    | C-6-'41<br>Maximilian Stern, M.D.<br>Daytona Beach       |
| Volusia<br>*Flagler                               | L. V. L. Brown, M.D.<br>DeLand                                      | R. L. Miller, M.D.<br>258 1/2 S. Beach St.<br>Daytona Beach        | 2nd Tuesday<br>7:30 P. M.                                              | 42      | 35   |                                                          |
| Hillsborough                                      | John R. Boling, M.D.<br>1207 First Nat. Bk. Bldg.<br>Tampa          | James S. Grabie, M.D.<br>811 Citizens Bank Bldg.<br>Tampa          | 1st Tuesday<br>8:00 P. M.                                              | 112     | 96   | D-7-'41<br>W. C. McConnell, M.D.<br>St. Petersburg       |
| Manatee                                           | M. M. Harrison, M.D.<br>Professional Bldg.<br>Bradenton             | W. E. Wentzel, M.D.<br>Box 245<br>Bradenton                        | 3rd Tuesday<br>7:00 P. M.                                              | 14      | 100% |                                                          |
| Pinellas                                          | John A. Herring, M.D.<br>259 Third St., No.<br>St. Petersburg       | W. C. McConnell, M.D.<br>313 First Federal Bldg.<br>St. Petersburg | 1st and 3rd Fridays<br>6:30 P. M.                                      | 105     | 100% |                                                          |
| Sarasota                                          | Millard B. White, M.D.<br>151 S. Pineapple Ave.<br>Sarasota         | Stanley T. Martin, M.D.<br>Sarasota                                | 2nd Tuesday<br>8:30 P. M.                                              | 15      | 4    | Southwest District (D)<br>Dunedin<br>Oct. 31, 1940       |
| DeSoto-Hardee-High-<br>lands-Charlotte-<br>Glades | Hartley E. Boorum, M.D.<br>37-38 S. Ridgewood Drive<br>Sebring      | Howard V. Weems, M.D.<br>22 Oak St.<br>Sebring                     | 2nd Tuesday<br>8:00 P. M.                                              | 21      | 100% | D-8-'41<br>H. V. Weems, M.D.<br>Sebring                  |
| Lee<br>*Collier, Hendry                           | A. S. Byle, M.D.<br>311 2nd St.<br>Fort Myers                       | Fred D. Bartleson, M.D.<br>Fort Myers                              | 3rd Friday<br>7:30 P. M.                                               | 14      | 100% |                                                          |
| Polk                                              | Henry Fuller, M.D.<br>Mulberry                                      | Jere W. Annis, M.D.<br>Box 1021<br>Lakeland                        | 2nd Wednesday<br>1:00 P. M.                                            | 62      | 56   |                                                          |
| Brevard                                           | I. M. Hay, M.D.<br>Melbourne                                        | I. K. Hicks, M.D.<br>Melbourne                                     | 3rd Tuesday                                                            | 10      | 9    | E-9-'41<br>J. R. Chappell, M.D.<br>Orlando               |
| Lake<br>*Sumter                                   | W. L. Ashton, M.D.<br>Umatilla                                      | Oliver Emerson, M.D.<br>Tavares                                    | 1st Thursday<br>12:30 P. M.                                            | 18      | 11   |                                                          |
| Orange<br>*Osceola                                | Chas. J. Collins, M.D.<br>269 Exchange Bldg.<br>Orlando             | Fred Mathers, M.D.<br>Box 53<br>Orlando                            | 3rd Wednesday<br>8:30 P. M.                                            | 82      | 81   |                                                          |
| Seminole                                          | Wade H. Garner, M.D.<br>Sanford                                     | Douglas G. Scott, M.D.<br>212 N. Park Ave.<br>Sanford              | 2nd Monday<br>7:00 P. M.                                               | 12      | 100% | South Central District (E)<br>Ft. Pierce<br>Nov. 1, 1940 |
| St. Lucie-Okeechobee<br>Indian River-Martin       | Francis A. Gowdy, M.D.<br>Ft. Pierce                                | Adrian M. Sample, M.D.<br>Ft. Pierce                               | 3rd Thursday<br>8:00 P. M.                                             | 19      | 18   | E-10-'41<br>A. M. Sample, M.D.<br>Ft. Pierce             |
| Broward                                           | L. B. Elliston, M.D.<br>814 Sweet Bldg.<br>Ft. Lauderdale           | E. C. Chamberlain, M.D.<br>720 Sweet Bldg.<br>Fort Lauderdale      | 4th Wednesday<br>8:00 P. M.                                            | 38      | 37   | F-11-'41<br>R. L. Elliston, M.D.<br>Ft. Lauderdale       |
| Palm Beach                                        | James H. Pittman, M.D.<br>Box 602<br>W. Palm Beach                  | C. Jennings Derrick, M.D.<br>Box 574<br>W. Palm Beach              | 4th Monday<br>8:00 P. M.                                               | 64      | 100% |                                                          |
| Dade                                              | Joseph S. Stewart, M.D.<br>525 duPont Bldg.<br>Miami                | Franz Stewart, M.D.<br>525 duPont Bldg.<br>Miami                   | 1st Tuesday<br>8:30 P. M.                                              | 310     | 220  | F-12-'41<br>Kenneth Phillips, M.D.<br>Miami              |
| Monroe                                            | Harry C. Galey, M.D.<br>532 Fleming St.<br>Key West                 | W. R. Warren, M.D.<br>511 Eaton St.<br>Key West                    | 1st Sunday<br>9:00 P. M.                                               | 5       | 100% | S. E. District (F)<br>Miami<br>Nov. 2, 1940              |

\*Supervise and aid until organized separately.



STATE AND SECTIONAL MEETINGS

| SOCIETY                             | PRESIDENT                          | SECRETARY                           | ANNUAL MEETING                    |
|-------------------------------------|------------------------------------|-------------------------------------|-----------------------------------|
| Florida Medical Association.....    | J. Sam Turberville, Century.....   | Shaler Richardson, Jacksonville.... | Jacksonville, 1941                |
| Florida Medical Districts:          |                                    |                                     |                                   |
| 1—Northwest .....                   | B. A. Wilkinson, Tallahassee.....  | Stewart Thompson, Jacksonville....  | Pensacola, Oct. 5, 1940           |
| 2—North Central .....               | William S. Nichols, Lake City....  | " " "                               | Lake City, Oct. 4, 1940           |
| 3—Northeast .....                   | Robt. B. McIver, Jacksonville....  | " " "                               | Daytona Beach, Oct. 3, 1940       |
| 4—Southwest .....                   | W. C. McConnell, St. Petersburg..  | " " "                               | Dunedin, Oct. 31, 1940            |
| 5—South Central .....               | A. M. Sample, Ft. Pierce.....      | " " "                               | Ft. Pierce, Nov. 1, 1940          |
| 6—Southeast .....                   | Kenneth Phillips, Miami.....       | " " "                               | Miami, Nov. 2, 1940               |
| Alabama Medical Association.....    | M. S. Davie, Dothan.....           | D. L. Cannon, Montgomery.....       |                                   |
| Georgia, Medical Assn. of.....      | W. H. Myers, Savannah.....         | E. D. Shanks, Atlanta.....          |                                   |
| Florida—                            |                                    |                                     |                                   |
| Chapter, Am. College Phys.....      | Louie M. Limbaugh, Jacksonville..  | Kenneth Phillips, Miami.....        | Jacksonville, 1941                |
| State Dental Society .....          | E. B. Penn, Miami.....             | E. C. Lunsford, Miami.....          | St. Petersburg, Nov., 1940        |
| Soc. of Derm. and Syph.....         | Alan Brown, Jacksonville.....      | Lauren M. Sompayrac, Jacksonville   | Jacksonville, 1941                |
| East Coast Medical Association..... | I. M. Hay, Melbourne.....          | J. S. Stewart, Miami.....           | Miami, 1940                       |
| State Hospital Association.....     | W. L. Shackelford, W. Palm Bch.    | Mr. T. F. Alexander, Jacksonville.. | New Orleans, 1941                 |
| Assn. of Industrial Surgeons.....   | A. M. Bidwell, Tampa.....          | T. H. Roberts, Lakeland.....        | Jacksonville, 1941                |
| Medical Postgraduate Course .....   | Turner Z. Cason, Jacksonville..... | Chairman                            | Jacksonville, June 24-29, 1940    |
| Soc. of Ophthal. & Otol.....        | H. Marshall Taylor, Jacksonville.. | Carl E. Dunaway, Miami.....         | Jacksonville, 1941                |
| State Nurses Association.....       | Mrs. M. Stetson, St. Petersburg    | Mrs. Phyllis Leonard, St. Augustine |                                   |
| Pediatric Society .....             | Warren W. Quillian, Coral Gables   | G. N. Leonard, Miami Beach.....     | Fall, 1940                        |
| Pharmaceutical Association .....    | Mr. S. F. Harris, Jacksonville..   | Mr. A. W. Morrison, Miami.....      | Tampa, May, 1940                  |
| Public Health Association .....     | A. B. McCreary, Jacksonville.....  | E. M. L'Engle, Jacksonville.....    | Tampa, Dec. 5-7, 1940             |
| Radiological Society .....          | J. H. Lucinian, Miami.....         | E. M. Hendricks, Ft. Lauderdale...  | Jacksonville, 1941                |
| Railway Surgeons' Association.....  | Leland F. Carlton, Tampa.....      | W. C. Page, Cocoa.....              | Jacksonville, 1941                |
| Tuberculosis & Health Assn.....     | Mr. E. M. Newald, Orlando.....     | Mrs. C. R. Whitaker, Eustis.....    |                                   |
| Attahoochee Valley Med. Assn.....   | M. Y. Dabney, Birmingham.....      | Frank K. Boland, Atlanta.....       | Albany, Ga., July 9-11, 1940      |
| 1st Coast Clinical Society.....     | J. H. Dodson, Mobile.....          | C. C. Rouse, Mobile.....            |                                   |
| Southeastern Derm. Assn.....        | Jack Jones, Atlanta.....           | Howard Hailey, Atlanta.....         | Atlanta, Ga., Sept. 1, 1940       |
| Southeastern Surgical Congress..... | Irvin Abell, Louisville.....       | B. T. Beasley, Atlanta.....         | Richmond, Va., Mar., 1941         |
| Southern Medical Association.....   | Arthur T. McCormack, Louisville    | Mr. C. P. Loran, Birmingham.....    | Louisville, Ky., Nov. 12-15, 1940 |
| Wanatee River Medical Society.....  | T. H. Bates, Lake City.....        | H. S. Howell, Lake City.....        |                                   |

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# The JOURNAL

of the

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### NEXT SESSIONS

American Medical Association, New York, June 10-14, 1940  
Florida Medical Association, Jacksonville, 1941  
Southern Medical Association, Louisville, Ky., November 12-15, 1940



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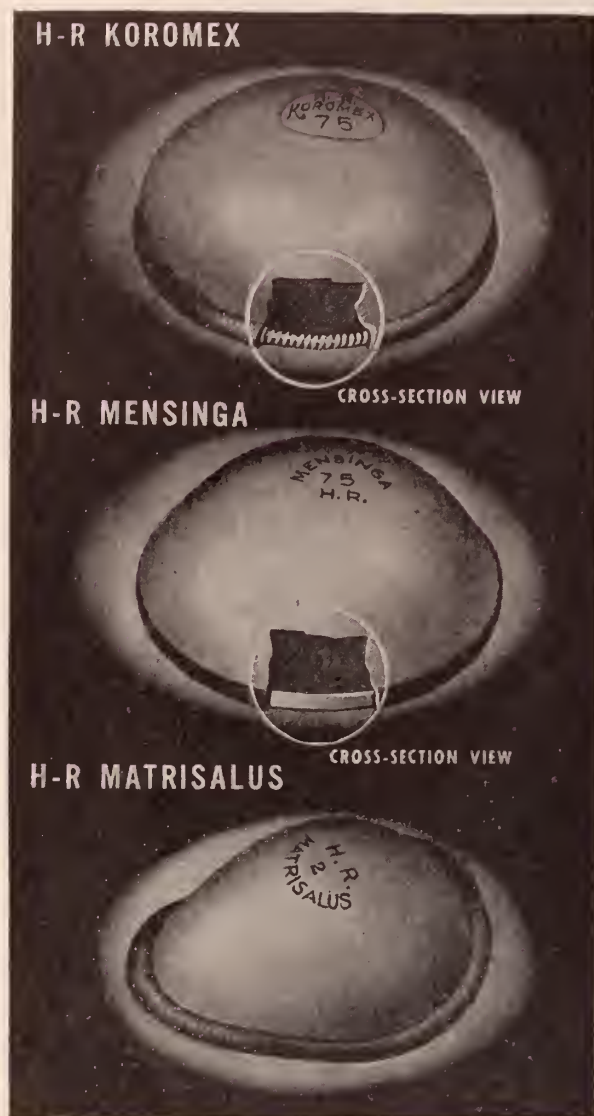
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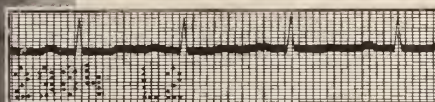
# STUDIES IN THE AVITAMINOSES



This page is the sixth of a series on vitamin deficiencies presented by the research division of The Upjohn Company because of the profession's widespread interest in the subject. A full color, two-page insert on the same subject appears in the May 25 issue of The Journal of the American Medical Association.

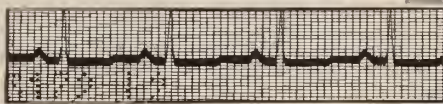


Teleoroentgenogram, at left, of alcoholic patient with severe thiamin deficiency, marked cardiac dilatation, congestive heart failure. X-ray below, taken after three weeks of thiamin chloride therapy, shows marked reduction in cardiac size. Patient received no digitalis.



Electrocardiogram on admission (Lead 2). Note the low voltage of the QRS complexes and of P and T waves. (Left)

After three weeks of thiamin chloride therapy. Note increased voltage, return of P waves. Later tracings showed normal T waves. (Lead 2)



Courtesy of Henry Field, Jr., M.D.,  
University of Michigan.



## The Cardiac Manifestations of Vitamin B<sub>1</sub> Deficiency

Vitamin B<sub>1</sub> apparently exerts no specific influence upon the normal heart, but profound deficiency resulting from drastic deprivation may lead to cardiac derangements which are as characteristic as the neural changes at times resulting from thiamin deprivation. In the cases reported, physical examination disclosed that the heart was enlarged to both the right and the left, although on postmortem examination of patients who died of extreme deficiency the enlargement was seen predominantly in the right auricle and ven-

tricle. The former was dilated and paper thin; the wall of the latter appeared thickened and its chamber enlarged. Some difference of opinion exists concerning the mechanism of the increase in cardiac size, since both hypertrophy and edema have been observed by different investigators.

The clinician, through whose courtesy the x-rays and electrocardiograms shown above are made available, states that administration of thiamin chloride promptly led to reduction in the cardiac silhouette.



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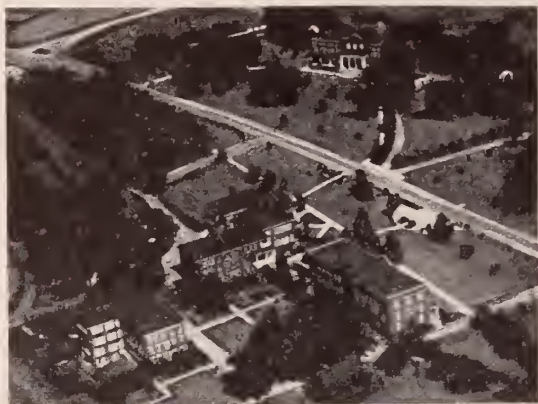
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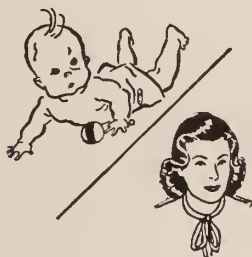
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## Grapefruit and the Maternal Diet



**N**ORMAL pregnancy and lactation greatly increase the demand for all of the food elements, because the fetus acts as a parasite. If its nutritional requirements are not met through the mother's diet, food materials are secured from her body, even to the extent of breaking down the maternal tissues. Calcium, for example, may be taken from her bones or teeth.

Of prime importance during this period is an abundant, well-balanced diet, one especially rich in calcium, vitamins, and mineral salts. The mother requires a generous intake of Vitamin C, both to maintain her own health and to ensure an adequate store to the infant at birth and a sufficient supply during lactation.

Citrus fruits are an outstanding source of Vitamin C, and they provide appreciable amounts of other vitamins as well as mineral salts, citrates, and easily assimilable sugars. *Moreover, the addition of citrus fruits to the diet increases the assimilation and retention of calcium derived from other foods.*

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The statements in this advertisement are based on the following numbered references in "Citrus Fruits and Health": 62, 63, 64, 65, 69.



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## President's Address

LEIGH F. ROBINSON, M. D.

Fort Lauderdale

I cannot proceed without first expressing my grateful appreciation for the great honor and privilege of serving you as President. During the year I have earnestly tried to keep before me the responsibilities of my office. While the high standards established by past presidents have oftentimes overwhelmed me, they have stimulated me to do my best. I have drawn freely and often upon the wisdom and experience of past presidents, fellow officers, and committeemen to help solve the many problems that have confronted us. Whatever of constructive value that has been accomplished only reflects the loyalty and cooperation of my fellow members. I especially want to express my gratitude to Dr. Stewart Thompson, our Managing Director, for his loyalty and cooperation. He is one of the most conscientious and efficient men with whom I have ever worked and to him must go the credit for the smoothness with which the machine of our organization moves along. Our many activities could not possibly be handled efficiently by your officers and committeemen without a dependable central office and personnel.

Nevertheless, however efficient our central office may be, sacrifice and cooperation of committeemen and members are required. The past year has been no exception with respect to faithfulness and sacrifice to duty. Your committees have met frequently and willingly. Sometimes committee members have been away from their offices two days at a time and while the Legislature was in session, members throughout the State were frequently called to Tallahassee. In addition to special committee meetings most of the officers and committee chairmen also attended the six district meetings held over the state.

### GROWTH OF ASSOCIATION

The steady growth of the Association is evidenced by the increase in its membership, which today is 1353, an increase of 60 over

one year ago. The strength of the Association as a whole lies largely in the hands of the 34 component medical societies. These individual units are headed by capable and enthusiastic officers. Three years ago district societies were organized and regular district meetings have been held since. The districts comprise the regular committee districts, which include two councilor districts. The senior councilor serves as President, and the junior councilor as President-elect. Dr. Stewart Thompson is the executive secretary of all the district organizations. District meetings are one of the most important steps that have ever been undertaken by the Association. They serve to bridge between the annual State meetings and give an opportunity for the officers and committeemen to visit all sections of the State in six visits. They also afford an opportunity for the officers and members to discuss their common problems in a more informal manner than is possible in the larger annual meeting. They allow for scientific programs and as a result increase the scientific interest of the membership. In like manner interest in the State Association has been stimulated and as a direct result the attendance at the annual meetings has increased.

### REFERENCE COMMITTEES

The percentage of members of the Association who are attending the annual conventions and the medical district meetings is rapidly increasing. Adequate facilities for entertaining at larger meetings, the increased representation in the House of Delegates, additional floor space for technical exhibits, meetings of special groups and planning the schedules for the sessions, all present a problem at present which did not formerly exist.

Last year at Daytona Beach you will recall that Dr. Gerry Holden, Delegate to the Georgia Convention, reported with what facility that House of Delegates worked through Reference Committees. After hearing the report it seemed that similar committees would increase

Presented before the Sixty-Seventh Annual Meeting of the Florida Medical Association held at Tampa, April 29, 30 and May 1, 1940.

the efficiency of our own House of Delegates. Doctor Holden agreed to work with us toward revising our system of schedules at the annual conventions. After several weeks of study and many meetings the Executive Committee met at Lakeland, September 27, and an entire evening was devoted to a discussion of the subject. The conclusion was that there should be a re-organization of the sessions at the annual conventions and that Reference Committees were necessary for adequate consideration of the business of the House of Delegates. Resolutions were therefore adopted that a revised schedule be worked out and Reference Committees be appointed for the present Convention. Those of us who have studied the question of Reference Committees feel that through them the work of the House of Delegates will be more efficiently handled. When a committee reports or a resolution is offered, it will be read at the first meeting of the House of Delegates and then referred immediately to a Reference Committee. Some time between the first and second meetings of the House the Reference Committees will meet, at which time any member of the House of Delegates or of the Association will be privileged to take part in the discussions.

There are now resolutions before the House of Delegates that this year's re-organization of convention procedure be adopted and made a permanent policy of the Association.

#### CARE IN SELECTION OF DELEGATES

While on the subject of the House of Delegates I want to emphasize the responsibility that rests on county societies when they are electing delegates to the State Convention. The responsibilities of the House of Delegates are increased due to the rapid growth of the Association. So often the delegates are the last officers to be selected at the County Society elections with the result that little care is taken in selecting men who not only deserve the honor but who will conscientiously perform the duties of their offices. Therefore, let me urge that each of you give particular attention to the selection of delegates who you are sure will properly represent you in the legislative body of the State Association.

#### THE COUNCILORS

Your Councilors under the leadership of Dr. Herman Watson have been most active during the year. They have brought before

all the county societies the importance that each county society become incorporated. The success of their efforts has been encouraging but there are many county societies that remain unincorporated. This work should be continued until every county society in our Association is properly incorporated.

Another activity of the Council which should be emphasized is that which has been done during the past year regarding organizing societies in the unorganized counties and bringing to the active list the inactive societies. Most of the counties so affected have too few physicians for carrying on the work of organized medicine. The Councilors have today introduced resolutions in the House of Delegates for a change in the by-laws which should make it possible to take organized medicine into every county of the State. Briefly this would be accomplished as follows: first, place unorganized counties under the supervision of nearby regular constituted societies until the time arrives that they have sufficient physicians to organize their own societies; second, in order to handle the situation created in counties where charters are held but due to so few members the societies are inactive, it is recommended that when a membership of any society falls below a total of three members its charter will automatically be cancelled, provided every effort has failed to bring the membership up to the necessary requirements. These recommendations are important to the counties affected, in order that the functions of public health and many medical problems may be handled by a constituted medical society rather than by lay bodies as is now being done.

#### POSTGRADUATE COURSE

One of the most constructive undertakings ever initiated by the Association was the establishment of a postgraduate course. One week of postgraduate instruction is offered the profession yearly for a registration fee of \$5.00. The courses have been of a practical general nature and planned in the interests of the general practitioner. During the year the Postgraduate Committee attended the District meetings and made a survey of the attitude of the membership toward postgraduate instruction. It was found that two out of every five members have attended the course during the five years since its introduction, and that the majority



avored the present plan and schedule. Every member of our Association who can avail himself of the opportunity should attend these lectures. Both the specialist and the general practitioner will find the time well spent.

#### TUBERCULOSIS AND CANCER CONTROL ACTIVITIES

Commendation is due the Tuberculosis and Public Health and the Cancer Control Committees for their cooperation and guiding influence in their work relative to the activities of the lay organizations which are sponsoring these great causes. Lay organizations which sponsor gigantic educational campaigns such as tuberculosis and cancer work need the help of the medical profession and, by the same rule, we need their help to successfully carry out the work of educational programs essential in the fields of preventive medicine.

#### SCHOOL HEALTH PROGRAM

A two weeks' conference beginning August 14, 1939, was held in Gainesville at the University of Florida in the interest of child health as concerns the school child. The idea of the meeting originated jointly in the State Department of Education at Tallahassee and the Department of Education of the University of Florida. Representatives from most of the organizations in Florida which are interested in the health of the school child were invited to the conference. Dr. Luther W. Holloway of Jacksonville was appointed to represent the Florida Medical Association. Our representative ably pointed out that the success of the movement initiated by the conference depended on the full cooperation of the educational authorities, the public health department, and organized medicine. It was emphasized that the Florida Medical Association stood ready at all times to do its part in molding a program related to questions of a medical nature. Medical knowledge is a requisite in promulgating plans in the interest of the health of the school child. Educational authorities were urged to contact the officers of our state and county medical societies in order to utilize properly the available medical knowledge in Florida.

#### STATE WIDE HEALTH COMMITTEES

During the year definite progress in the interest of public health was made by the State-Wide Public Health Committee. We were represented on this Committee and found the lay

members cooperative and sympathetic with organized medicine's viewpoint. Last November this committee effected a permanent organization. Emphasis was placed on full cooperation with the State Board of Health, the Florida Medical Association and other recognized health agencies to improve the standards of health in Florida. The objectives of this organization should receive the endorsement of the medical profession.

#### THE NEW BASIC SCIENCE LAW

The physicians of Florida in recent years have awakened to the importance of the influence of politics. For more than a decade our Legislative Committees have gone to Tallahassee and worked diligently in the interests of the profession. During this period the different Legislative Committees along with their other duties have worked for the enactment of a Basic Science Law. Last spring at the 1939 session of the Legislature a Basic Science Bill was passed and the Governor has appointed a competent Board of Basic Science Examiners. The final success of this struggle we believe was due, first, to the hard preliminary ground work built up by former Legislative Committees; second, to the determination and efforts of this year's Committee; and, last but most important, to the wholehearted support of the membership who contacted the rank and file of the Legislators. The Basic Science Law is one of the most important public health measures ever placed on the statutes. This law does not discriminate against any school of the healing art; it affects all the different schools equally. It is not retroactive and can discriminate against no individual, regardless of the system he practices. The law does guarantee to the public that no matter from what board of examiners the practitioner may in the future receive his license, he has had at least an elementary knowledge of anatomy, physiology, bacteriology, pathology and chemistry.

#### LEGISLATIVE DUTIES

While on the subject of legislative work, the questions naturally arise: What of the future? Will there be an attempt to repeal the Basic Science Law? Will there be bills introduced in future Legislatures that may endanger the public health and lower the standards of the practice of medicine? The answer is YES, most certainly so! Then what are we going to

do about it? Shall we continue to follow our present plan of handling legislation through a Legislative Committee and, if so, will the Association be favorable toward annually setting aside certain sums of money for legislative work? Will the Association approve the employment of legislative counsel on the theory that the work at Tallahassee is more than the Committee should be expected to do unassisted? Or should the present plan of handling legislative work be discarded in favor of a State Physicians' Committee, similar to the recently organized National Physicians' Committee? Would a committee of this character because it would not be a part of the Association accomplish in a more efficient manner, many things that the Association as a scientific organization cannot? These questions must be answered before the next session of the Legislature. We should give them our most serious consideration and adopt a legislative procedure that will protect the interests of organized medicine.

#### PUBLIC RELATIONS ACTIVITIES

Our Public Relations Committee through its active chairman has made progress this year but, with more encouragement and substantial support, much more could be accomplished. It is urged that a more aggressive

policy be adopted in order that the public may be made thoroughly acquainted with the dangers of socialized medicine.

The Medical Auxiliary can assist us in our public relations. The Auxiliary controls channels for disseminating information that penetrates every part of hundreds of communities in the State. Through their lay contacts the individual members are in key positions to promulgate educational programs. The Florida Medical Association should frequently requisition the services of this important organization to combine their efforts for the common good.

Before closing, I would like to go into many other phases of the work sponsored and accomplished by your Association, but I have tried to limit my remarks to subjects and projects initiated or completed during the year, and to recommendations and suggestions that it is believed would improve the service to the membership. I cannot but express a feeling of regret as my term of office draws to an end. Words are too inadequate to express my gratitude and appreciation for the highest honor that the Florida Medical Association has bestowed upon one of its members. Thank you!

*720 Sweet Building.*



**Where?** To the Medical District Meetings.

**Why?**

- To hear good scientific papers.
- To meet the officers of the Association.
- To discuss medical problems.
- To renew acquaintances.
- To have a good time.

**When?**

- Daytona Beach (C), October 3—Thursday.
- Lake City (B), October 4—Friday.
- Pensacola (A), October 5—Saturday.
- Dunedin (D), October 31—Thursday.
- Ft. Pierce (E), November 1—Friday.
- Miami (F), November 2—Saturday.

**GROWING EVER MORE POPULAR —  
THE DISTRICT MEETINGS OF THE  
FLORIDA MEDICAL ASSOCIATION**



# PROCEEDINGS

of the

## SIXTY-SEVENTH ANNUAL MEETING

of the

### FLORIDA MEDICAL ASSOCIATION, Inc.

#### HELD AT TAMPA, FLORIDA

#### APRIL 29, 30 AND MAY 1, 1940

#### FIRST MEETING OF HOUSE OF DELEGATES

The House of Delegates convened at 1:30 p. m., Monday April 29, 1940 in the Chamber of Commerce Building, Tampa, with Dr. Leigh F. Robinson, president, in the chair. The following delegates were seated and answered roll call:

#### DELEGATES

ALACHUA—E. H. Andrews.  
BAY—W. C. Roberts.  
BREVARD—T. C. Kenaston.  
BROWARD—R. L. Elliston, E. M. Hendricks.  
COLUMBIA—R. B. Harkness.  
DADE—W. C. Jones, Jr., M. J. Flipse, W. D. Owens, Kenneth Phillips, R. M. Harris, J. S. Stewart, H. A. Walker, H. L. Pearson, E. S. Nichol, Franz Stewart.  
DESOTO-HARDEE, et al.—I. W. Chandler.  
DUVAL—C. B. Mabry, S. E. Driskell, R. B. McIver, F. J. Waas, Edward Jelks, L. W. Holloway, N. A. Upchurch, T. E. Buckman, L. Y. Dyrenforth.  
ESCAMBIA—H. L. Bryans, J. N. McLane.  
FRANKLIN-GULF—Thomas Meriwether.  
HILLSBOROUGH—W. M. Rowlett, R. S. Torbett, H. M. Smith, J. W. Alsobrook, T. C. Maguire.  
JACKSON—N. A. Baltzell.  
LAKE—C. M. Tyre.  
LEE—H. Q. Jones.  
LEON-GADSDEN, et al.—F. T. Holland, J. K. Johnston.  
MADISON—No Delegate.  
MANATEE—T. M. McDuffee.  
MARION—E. G. Peek.  
MONROE—No delegate.  
ORANGE—T. E. McBride, H. A. Day, J. R. Chappell, C. J. Collins.  
PALM BEACH—L. J. Netto, F. K. Herpel, J. H. Pittman.  
PASCO-HERNANDO, et al.—No delegate.  
PINELLAS—J. A. Herring, W. C. McConnell, E. C. MacCordy, W. M. Davis, Grace R. Whitford.  
POLK—Herman Watson, R. L. Cline, J. R. Boulware, Jr.  
PUTNAM—A. P. Gurganious.  
ST. JOHNS—H. E. White.  
ST. LUCIE-OKEECHOBEE, et al.—M. D. Council.  
SARASOTA—M. B. White.  
SEMINOLE—T. F. McDaniel.  
SUMTER—No delegate.  
TAYLOR—No delegate.  
VOLUSIA—J. E. Rawlings, Ludo von Meysenbug.  
WALTON-OKALOOSA—C. W. McDonald.  
WASHINGTON-HOLMES—F. M. Watson  
ASSOCIATION OFFICERS—L. F. Robinson, J. S. Turberville, J. R. Wells, T. H. Bates, J. W. Taylor, Shaler Richardson.

It was moved and seconded that the minutes of the last meeting, as published in the June, 1939 issue of the Florida Medical Journal, be adopted. There being no corrections or amendments, the minutes as published were adopted by unanimous vote.

It was moved and seconded that three reference committees be appointed as indicated in the printed program.

Doctor Peek: I feel that the membership of reference committees should be composed of members of the House of Delegates.

Doctor Herpel: The president is not in a position to know the members of the House of Delegates three or four months in advance. Our experience in previous years has been to spend most of the time in useless talk. The proposed plan I think is one that will get to the bottom of things quickly. However, the heads of standing committees should be more familiar than other persons with the matters to come before the reference committees for recommendations.

Doctor Day: The reference committee should be composed of members of the House of Delegates.

Doctor Walker: I think that this point is well taken—that the personnel of these reference committees should be composed of members of the House of Delegates.

Doctor Robinson: Your Executive Committee discussed this question on several occasions and decided the reference committees should be appointed well in advance of the annual meeting and be fully acquainted with the work of the Association during the year. To be legal, according to our Constitution and By-Laws, the members of reference committees do not necessarily have to be members of the House of Delegates.

Doctor Flipse moved to amend the motion by accepting the individuals named in the printed program as members of the reference committees, who are delegates, and that the chair complete the committees by appointment from members of this House of Delegates and announce at this session the personnel of the three reference committees. Seconded by Doctor Peek.

It was recommended that each reference committee be composed of five members, three of whom shall constitute a quorum. Recommendation accepted by Doctor Flipse and Doctor Peek.

Doctor Wells: These committees have no power to act. They only make recommendations to the House of Delegates. It makes no difference whether or not they are members.

Doctor Day: As a matter of precedent I feel that these individuals should be appointed from the membership of the House of Delegates.

The question was called for and the amendment passed by a standing vote. A vote was then taken on the original motion as amended, which prevailed.

Our delegates to the A. M. A. House of Delegates were then recognized.

Doctor Bryans responded: We have two delegates to the A. M. A. Doctor Mallory made his report to the Executive Committee some time ago. Since then, between the two of us, we have attended a number of district medical meetings. A report was read each time and published in the Journal. At this time we have nothing further to add.

On motion by Dr. Hendricks, our delegates' report was accepted.

Doctor Robinson called for the nomination of one delegate to the House of Delegates of the A. M. A. for a two-year term. Dr. H. L. Bryans was nominated by Doctor Herpel. Dr. Edward Jelks was nominated by Doctor Waas. Doctor Day moved that nominations be closed. The motion prevailed. The result of the ballot vote was announced: 48 for Doctor Jelks and 19 for Doctor Bryans. Doctor Jelks having received a majority vote, the chair declared him elected for a two-year term, January 1, 1941 to December 31, 1942.

The chair called for nominations for an alternate. Dr. H. L. Bryans was nominated by Doctor W. C. Roberts. A motion to close the nominations and declare Doctor Bryans elected as alternate prevailed.

A resolution was read by Dr. James R. McEachern, suggesting the dissolution of the Committee on Tuberculosis and Public Health and creating two separate committees, one on Tuberculosis and one on Public Health. On motion the resolution was received and referred by the chair to Reference Committee No. 1, Health and Education.

A resolution was read by Dr. H. L. Bryans, requesting the State Association to propose legislation to amend the Optometrists' Law as requested by the Escambia County Medical Society. On motion the resolution was received and referred by the chair to Reference Committee No. 2, Public Policy.

A resolution was read by Dr. M. D. Council, suggesting legislation requiring tax collectors

before issuing occupational licenses, to ascertain if applicants have their M. D. licenses. On motion the resolution was received and referred by the chair to Reference Committee No. 2, Public Policy.

A resolution was read by Dr. L. B. Elliston, suggesting the appointment of a committee to study forms for recording case histories, as requested by the Broward County Medical Society. On motion the resolution was received and referred by the chair to Reference Committee No. 1, Health and Education.

A resolution was read by Dr. J. S. Stewart, requesting the Southeastern Surgical Association to hold its 1942 convention in Miami. On motion the resolution was received and referred by the chair to Reference Committee No. 1, Health and Education.

A resolution was read by Dr. T. E. McBride, concerning proposed legislation for unclaimed dead human bodies upon request being delivered to component county medical societies. On motion the resolution was received and referred by the chair to Reference Committee No. 2, Public Policy.

A resolution was read by Dr. Edward Jelks concerning legislation for reorganization of the State Board of Health. On motion the resolution was received and referred by the chair to Reference Committee No. 2, Public Policy.

The report of the Executive Committee was read by Dr. G. S. Osincup, chairman. On motion the report was received and referred by the chair to Reference Committee No. 3, Finance.

The report of the Committee on Scientific Work was read by Dr. Walter C. Jones, Jr., chairman. On motion the report was received and referred by the chair to Reference Committee No. 1, Health and Education.

The report of the Committee on Publication was read by Dr. Walter C. Jones, Jr., chairman. On motion the report was received and referred by the chair to Reference Committee No. 1, Health and Education.

The report of the Committee on Legislation and Public Policy was read by Dr. H. A. Day, chairman, and on motion, was received and referred by the chair to Reference Committee No. 2, Public Policy.

The report of the Committee on Medical Education and Hospitals was read by Dr. J. R. Chappell, chairman, and on motion, was



received and referred by the chair to Reference Committee No. 2, Public Policy.

The report of the Committee on Public Relations was read by Dr. J. R. Wells, chairman, and on motion, was received and referred by the chair to Reference Committee No. 2, Public Policy.

The report of the Committee on Necrology was read by Dr. H. A. Barge, chairman, and on motion, was received and referred by the chair to Reference Committee No. 1, Health and Education.

The report of the Committee on Medical Economics was read by Dr. H. A. Walker, chairman, and on motion, was received and referred by the chair to Reference Committee No. 2, Public Policy.

The report of the Committee on Venereal Disease Control was read by Dr. E. T. Sellers, chairman, and on motion, was received and referred by the chair to Reference Committee No. 1, Health and Education.

The report of the Committee on Cancer Control was read by Dr. J. M. Hoffman, chairman, and on motion, was received and referred by the chair to Reference Committee No. 1, Health and Education.

The report of the Committee on Inter-Relationship was read by Dr. E. C. Swift, chairman, and on motion, was received and referred by the chair to Reference Committee No. 2, Public Policy.

The Report of the Committee on Tuberculosis and Public Health was read by Dr. M. J. Flipse, chairman, and on motion, was received and referred by the chair to Reference Committee No. 1, Health and Education.

The report of the Committee on Medical Postgraduate Course was read by Dr. T. Z. Cason, chairman, and on motion, was received and referred by the chair to Reference Committee No. 1, Health and Education.

The report of the Committee on State Controlled Medical Institutions was read by Dr. G. A. Dame, chairman, and on motion, was received and referred by the chair to Reference Committee No. 2, Public Policy.

The report of the Committee on Maternal Welfare was read by Dr. Ferdinand Richards, chairman, and on motion, was received and referred by the chair to Reference Committee No. 1, Health and Education.

The report of the Committee on Child Health

was read by Dr. W. W. Quillian, chairman, and on motion, was received and referred by the chair to Reference Committee No. 1, Health and Education.

The report of the Advisory Committee to Woman's Auxiliary, at the request of the chairman, Dr. G. H. Ira, was referred by the chair to Reference Committee No. 2, Public Policy.

The report of the Council was read by Dr. Herman Watson, chairman, and on motion, was received and referred by the chair to Reference Committee No. 3, Finance.

A verbal report was given from the General Advisory Board of Past Presidents by Dr. J. H. Pierpont, chairman.

An application signed by nine doctors was presented for a charter to be issued a society to be known as the Madison-Suwannee County Medical Society. On motion the application was received and referred by the chair to Reference Committee No. 3, Finance.

Dr. F. J. Walter of San Diego, California was introduced. He was president of the Florida Medical Association in 1918.

In accordance with action taken during this meeting, the chair announced the personnel of three reference committees as follows:

NO. 1—HEALTH AND EDUCATION:

W. C. Jones, Jr., Chairman  
Frederick J. Waas  
R. L. Elliston  
F. K. Herpel  
M. J. Flipse

NO. 2—PUBLIC POLICY:

H. A. Walker, Chairman  
H. A. Day  
J. R. Chappell  
J. R. Wells  
Edward Jelks

NO. 3—FINANCE:

Shaler Richardson, Chairman  
H. L. Bryans  
J. S. Stewart  
Herman Watson  
L. F. Robinson

On motion seconded and carried, the House recessed at 6:30 p. m. to reconvene Tuesday, April 30 at 4:30 p. m.

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## FIRST GENERAL SESSION

The Sixty-Seventh Annual Meeting of the Florida Medical Association was called to order at 4:30 p. m., Monday, April 29 in the Palm Room of the Tampa Terrace Hotel, Tampa, by President Leigh F. Robinson.

Invocation by the Rev. John B. Walthour.  
Dr. John R. Boling, president of the Hills-

borough County Medical Society, gave the address of welcome.

Doctor Boling: On behalf of the Hillsborough County Medical Society I wish to extend to you a welcome that is very sincere. We, as members of the Hillsborough County Medical Society and as people of Tampa, are proud to entertain guests of such distinction. I think probably you will understand more fully the sincerity of this welcome if I tell you that every member of our Medical Society has given freely and enthusiastically of his time and of his effort to make preparations for your entertainment. We know that you are going to enjoy the scientific program that has been prepared by your scientific program committee. And we do hope that you will enter into and enjoy the social and sports events that have been arranged for you and that when you leave you will go away with a feeling of satisfaction and knowledge that your time has been well spent. We welcome you and we thank you for the opportunity of being your hosts.

By request, Dr. J. R. Wells, first vice-president, took the chair. The presidential address was then delivered by Dr. L. F. Robinson (*See page 593*). A rising vote of thanks was accorded President Robinson in appreciation of his splendid work during the past year.

The following report of the secretary-treasurer and editor of the Journal, Dr. Shaler Richardson, and managing director, Dr. Stewart Thompson, was read by Doctor Richardson:

REPORT OF SECRETARY-TREASURER,  
EDITOR OF THE JOURNAL, DR. SHALER  
RICHARDSON; AND MANAGING DI-  
RECTOR, DR. STEWART THOMPSON

*To the President and Members of the Florida Medical Association in Session at Tampa, Florida:*

You will undoubtedly be gratified to learn through this, our fifteenth annual report, that favorable results far beyond general expectations have been realized. Operating expenses in a very much enlarged program of activities totaled almost \$24,000.00 for the past year. Increases in revenue, however, were realized to such an extent that the deficit for the year was only \$361.94. The membership last year totaled 1,353, as compared to 1,293 for the previous year. This represents a net increase of 60 members. This total of 1,353 members was published in the Florida Medical Directory by component societies and will, therefore, not be reproduced here. The Dade County Medical Society headed the list with 294 members; the Duval County Medical Society had 176; the Hillsborough County Medical Society, 107; and the Pinellas County Medical Society, 104. The attendance at last year's annual convention was 620, the attendance at the six annual medical district meetings was 562 and at the Pre-Convention meeting, 50, making a total attendance at the eight annual meetings of 1,232. It is interesting to note that the total at the medical district meetings last year was 562, as compared to 445 for the previous year.

The personnel of your office has assisted the officers of the Association, the regular committees and the Council in the various activities throughout the year. Your home office and Journal are maintained for all of the members. Since they are your office and your Journal, we hope that you will contribute suggestions and constructive criticism from time to time and thus make it possible to carry on the work according to your wishes. The circulation of your Journal is steadily increasing. During the year 19,120 Journals were mailed

out and 62 scientific papers were published in the Journal. Articles of our members published in out-of-state journals and abstracted for publication in your Journal totaled 24.

The 1940 Florida Medical Directory was mailed to 2,400 doctors. This Directory seems to be accepted as a useful reference book not only for our own members, but also for detail men, health departments and various concerns interested in the contents of this publication. In the section devoted to medical laws the new Basic Science Law has been reproduced. The advertisements and sale of Directories have more than covered the total cost of printing.

In your office 28,037 letters and forms were produced on the mimeograph; a total of 12,492 letters were mailed; and 4,684 letters were received through the mail. In addition to this, 1,233 medical journals were received and filed.

#### FINANCES

The financial statements appearing at the end of this report will be published in full. Receipts during the fiscal year totaled \$23,496.40. Disbursements were \$23,858.34, leaving a deficit of \$361.94. Since there were some unusual expenditures during the past year, this deficit should be easily wiped out before the next annual meeting. For the benefit of those members who do not study the financial statements, the Association's revenue is derived largely as follows:

Dues and entrance fees, \$14,250; earnings from advertising in the Journal and Medical Directory, \$5,722.77; subscriptions to the Journal and sale of Medical Directories, \$578.55; interest on savings and investments, \$532.38; and rental on technical exhibits, \$2,245.70.

Expenditures during the year included, from the general fund, \$9,124.58; printing of the Journal and Directory, \$8,161.58; percentage to entertaining society, \$831.00; convention expense, \$604.48, taken from exhibit fund; expenses of standing committees, \$4,401.54; office equipment, \$600.72; library, \$22.65; and Federal tax, \$26.79. In addition to increasing the actual revenue, the assets of your Association are supplemented by many methods of economy. For example, the price of paper stock for your Journal and Medical Directory has advanced a number of times during the year. When these advances were observed, a year's supply of paper stock was purchased through a wholesale paper company, and stored. Since the purchase of this year's supply, the price has advanced several times. The Association, therefore, is realizing a substantial saving by not being subjected to the increases.

Advertising income for the past year was \$5,722.77 as compared to \$5,230.69 for the previous year, making an increase of \$492.08. This increase in advertising revenue is a substantial gain, since there have been increases from year to year.

Diligent effort has been put forth to increase the membership, organize new county medical societies, raise the standard of and interest in your Journal, make your Medical Directory a valuable reference book, increase advertisements, and in every way possible make your home office a service station available to the entire membership.

The chairman of the Executive Committee in his report to the House of Delegates this afternoon stated that the income of the Association surpassed disbursements to the extent of \$1,682.63 during the past three years, notwithstanding the fact that the activities of the Association have been greatly enlarged, a full time managing director employed and a number of unusual expenditures authorized and paid.

The books and records of the Association are open to our members and we will be glad to answer inquiries as far as possible, of any nature. The books have been audited by Ford and Colley and a certification thereof is incorporated in the statements which follow.

Respectfully submitted,

Shaler Richardson  
Stewart G. Thompson



FORD & COLLEY  
CERTIFIED PUBLIC ACCOUNTANTS

Jacksonville, Florida, April 25, 1940.

Dr. Shaler Richardson, Treasurer,  
Florida Medical Association, Incorporated,  
Jacksonville, Florida.

Dear Sir:

We have examined the attached statements of Cash Receipts and Disbursements of Florida Medical Association, Incorporated, for the period begun April 20, 1939, and ended April 15, 1940. These statements have been prepared by Dr. S. G. Thompson, Managing Director of the Association and the Florida Medical Journal, and Miss Naomi Anderson, bookkeeper, and correctly reflect the cash transactions for the period stated as shown by the books of account. The books are in excellent condition.

We have checked the additions of the cash records, and have compared the disbursements as entered therein with the cancelled checks returned by the bank. We have checked the recorded collections to the bank deposits as shown by the bank's statements, and have obtained the written confirmation of the bank as to the balance at the close of the period. We have obtained the written confirmations of the banks as to the savings accounts. We have checked the general ledger postings, and have verified general ledger additions.

As we do not have access to the records of the various County Societies for the purpose of checking the remittances of dues, attention is directed to Exhibit "D" which gives details regarding this matter.

Income from Journal advertising was verified substantially by comparison with a detailed statement of contracts with advertisers furnished by you.

The ten United States bonds, par value \$1,000.00 each, were verified by us with The Atlantic National Bank of Jacksonville, Florida.

Yours very truly,

FORD & COLLEY

CONSOLIDATED CASH STATEMENT

April 21, 1939 through April 15, 1940

*Receipts*

|                                                              |              |           |
|--------------------------------------------------------------|--------------|-----------|
| Cash in Bank, April 21, 1939.....                            | \$ 24,755.93 |           |
| Dues and Entrance Fees Collected<br>(Exhibit "D").....       | \$14,250.00  |           |
| Earnings from Advertising<br>(Exhibit "E").....              | 5,722.77     |           |
| Subscription and Misc. Sale of<br>Journal and Directory..... | 578.55       |           |
| Interest on Savings and<br>Investment.....                   | 532.38       |           |
| Voluntary Donations.....                                     | 164.00       |           |
| Sale of Books by C. W. Warner.....                           | 3.00         |           |
| Earnings—Technical Exhibits<br>(Exhibit "C").....            | 2,245.70     | 23,496.40 |
| Total Cash to be Accounted for.....                          | \$ 48,252.33 |           |

*Disbursements*

|                                                      |              |           |
|------------------------------------------------------|--------------|-----------|
| General Fund Expenses<br>(Exhibit "A").....          | \$ 9,124.58  |           |
| Journal and Directory Expenses<br>(Exhibit "B")..... | 8,161.58     |           |
| Technical Exhibit Expenses<br>(Exhibit "C").....     | \$604.48     |           |
| To Entertaining Society.....                         | 831.00       | 1,435.48  |
| Committee Expenses<br>(Exhibit "A").....             | 4,401.54     |           |
| Furniture, Fixtures and<br>Equipment.....            | 600.72       |           |
| Library.....                                         | 22.65        |           |
| Federal Tax.....                                     | 26.79        |           |
| Medicolegal Aid.....                                 | 85.00        | 23,858.34 |
| Balance in Bank, April 15, 1940.....                 | \$ 24,393.99 |           |

EXHIBIT "A"

CASH STATEMENT—GENERAL FUND

April 21, 1939 through April 15, 1940

*Receipts*

|                                               |              |           |
|-----------------------------------------------|--------------|-----------|
| Cash as per last audit.....                   | \$ 24,755.93 |           |
| Back dues collected<br>(Exhibit "D").....     | \$ 2,510.00  |           |
| Current dues collected<br>(Exhibit "D").....  | 10,580.00    |           |
| Entrance Fees collected<br>(Exhibit "D")..... | 1,160.00     | 14,250.00 |
| Interest on Savings and Investment.....       | 532.38       |           |
| Voluntary Donations.....                      | 164.00       |           |
| Sale of Books by C. W. Warner.....            | 3.00         |           |
| From Exhibit Fund.....                        | 810.22       |           |
| Total Cash to be Accounted for.....           | \$ 40,515.53 |           |

*Disbursements*

|                                                                                |             |           |
|--------------------------------------------------------------------------------|-------------|-----------|
| Postage and Supplies.....                                                      | \$ 405.14   |           |
| Telephone and Telegraph.....                                                   | 312.65      |           |
| Salaries.....                                                                  | 6,720.00    |           |
| Traveling Expense.....                                                         | 481.85      |           |
| Delegates (2) Transp. to<br>St. Louis.....                                     | 115.60      |           |
| Legal Counsel.....                                                             | 100.00      |           |
| Office Rent.....                                                               | 720.00      |           |
| Towel Service.....                                                             | 15.00       |           |
| Auditing Books.....                                                            | 12.50       |           |
| Messenger Service.....                                                         | 18.35       |           |
| Express and Freight.....                                                       | 12.45       |           |
| Bank Exchange.....                                                             | 3.04        |           |
| Custody of Bonds.....                                                          | 10.00       |           |
| Photostats and Legal Copies.....                                               | 10.95       |           |
| News Service.....                                                              | 40.00       |           |
| Clipping Service.....                                                          | 60.00       |           |
| Treasurer's Bond.....                                                          | 18.75       |           |
| Subscription—<br>Times Union.....                                              | 10.00       |           |
| Employers' Liability<br>Insurance.....                                         | 23.00       |           |
| Repair Furniture, clean and<br>repair typewriters, adding<br>machine, etc..... | 25.60       |           |
| Incidental.....                                                                | 9.70        | 9,124.58  |
| Committees:                                                                    |             |           |
| Council.....                                                                   | 194.86      |           |
| Legislative.....                                                               | 4,119.40    |           |
| Postgraduate Course.....                                                       | 2.91        |           |
| Hospital.....                                                                  | 1.85        |           |
| Executive.....                                                                 | 60.02       |           |
| Scientific Work.....                                                           | 4.05        |           |
| Misc. Committee Expense.....                                                   | 18.45       | 4,401.54  |
| Furniture, Fixtures and<br>Equipment.....                                      | 600.72      |           |
| Library.....                                                                   | 22.65       |           |
| Federal Tax.....                                                               | 26.79       |           |
| Medicolegal Aid.....                                                           | 85.00       |           |
| To Jnl. and Directory Fund<br>(Cost above Income).....                         | 1,860.26    | 16,121.54 |
| CASH BALANCE.....                                                              | \$24,393.99 |           |

## EXHIBIT "D"

Dues and Entrance Fees Collected April 21, 1939 through April 15, 1940

| Name of Society                                    | Total<br>Members | Number<br>Paid | No. in<br>Arrears | 1940 Dues<br>Collected | Back Dues<br>Collected | Entrance<br>Fees |
|----------------------------------------------------|------------------|----------------|-------------------|------------------------|------------------------|------------------|
| Alachua .....                                      | 30               | 21             | 9                 | \$ 180.00              | \$ 70.00               | \$ 10.00         |
| Bay .....                                          | 11               | 8              | 3                 | 60.00                  |                        | 10.00            |
| Brevard .....                                      | 10               | 9              | 1                 | 80.00                  | 20.00                  | 10.00            |
| Broward .....                                      | 38               | 37             | 1                 | 360.00                 | 10.00                  | 50.00            |
| Columbia .....                                     | 19               | 10             | 9                 | 80.00                  | 50.00                  | 20.00            |
| Dade .....                                         | 311              | 203            | 108               | 1,960.00               | 1,160.00               | 350.00           |
| DeSoto-Hardee-Highlands-<br>Charlotte-Glades ..... | 20               | 20             | 0                 | 190.00                 | 10.00                  | 10.00            |
| Duval .....                                        | 179              | 176            | 3                 | 1,670.00               | 90.00                  | 110.00           |
| Escambia .....                                     | 44               | 35             | 9                 | 330.00                 | 110.00                 | 10.00            |
| Franklin-Gulf .....                                | 6                | 6              | 0                 | 50.00                  |                        |                  |
| Hillsborough .....                                 | 111              | 84             | 27                | 810.00                 | 290.00                 | 90.00            |
| Individuals .....                                  | 5                | 0              | 5                 |                        |                        |                  |
| Jackson .....                                      | 12               | 8              | 4                 | 70.00                  |                        |                  |
| Lake .....                                         | 18               | 11             | 7                 | 100.00                 | 40.00                  | 10.00            |
| Lee .....                                          | 14               | 14             | 0                 | 130.00                 | 20.00                  | 10.00            |
| Leon-Gadsden-Liberty-<br>Wakulla-Jefferson .....   | 38               | 31             | 7                 | 270.00                 | 110.00                 | 60.00            |
| Madison .....                                      | 3                | 2              | 1                 | 10.00                  | 10.00                  |                  |
| Manatee .....                                      | 14               | 14             | 0                 | 120.00                 |                        |                  |
| Marion .....                                       | 24               | 24             | 0                 | 200.00                 | 10.00                  | 20.00            |
| Monroe .....                                       | 5                | 5              | 0                 | 40.00                  |                        |                  |
| Orange .....                                       | 81               | 79             | 2                 | 770.00                 | 180.00                 | 80.00            |
| Palm Beach .....                                   | 64               | 60             | 4                 | 580.00                 | 120.00                 | 60.00            |
| Pasco-Hernando-Citrus .....                        | 15               | 14             | 1                 | 130.00                 | 10.00                  | 10.00            |
| Pinellas .....                                     | 105              | 105            | 0                 | 990.00                 | 60.00                  | 160.00           |
| Polk .....                                         | 62               | 54             | 8                 | 520.00                 | 10.00                  | 40.00            |
| Putnam .....                                       | 11               | 6              | 5                 | 50.00                  | 20.00                  |                  |
| St. Johns .....                                    | 10               | 9              | 1                 | 80.00                  | 10.00                  | 10.00            |
| St. Lucie-Okeechobee-Indian<br>River-Martin .....  | 18               | 16             | 2                 | 140.00                 |                        | 10.00            |
| Sarasota .....                                     | 15               | 4              | 11                | 30.00                  | 50.00                  |                  |
| Seminole .....                                     | 12               | 12             | 0                 | 110.00                 |                        |                  |
| Sumter .....                                       | 2                | 0              | 2                 |                        |                        |                  |
| Taylor .....                                       | 7                | 6              | 1                 | 50.00                  | 10.00                  |                  |
| Volusia .....                                      | 42               | 35             | 7                 | 340.00                 | 30.00                  | 20.00            |
| Walton-Okaloosa .....                              | 6                | 6              | 0                 | 50.00                  |                        |                  |
| Washington-Holmes .....                            | 8                | 4              | 4                 | 30.00                  | 10.00                  |                  |
| TOTALS .....                                       | 1,370            | 1,128          | 242               | 10,580.00              | 2,510.00               | 1,160.00         |
|                                                    |                  |                |                   | 2,510.00               | Back dues Collected    |                  |

EMERGENCY FUND—(Memorandum No. 3)  
(Taken from Treasurer's Financial Statement)  
April 21, 1939 through April 15, 1940

*Debit*

|                                                                              |            |
|------------------------------------------------------------------------------|------------|
| Balance on hand, April 21, 1939 .....                                        | \$2,062.96 |
| (Memorandum No. 2)                                                           |            |
| Back dues Collected (Exhibit "D")<br>\$2,510.00 (251 members @ \$2.50) \$    | 627.50     |
| Current dues Collected (Exhibit "D")<br>\$10,580.00 (1,058 members @ \$2.50) | 2,645.00   |
| Voluntary Donations .....                                                    | 164.00     |
| To be Accounted for .....                                                    | \$5,499.46 |
| Less Amount Reserved for Working<br>Budget and Expended .....                | 1,500.00   |
| Balance .....                                                                | \$3,999.46 |

*Credit*

|                           |           |
|---------------------------|-----------|
| Committee Expenses:       |           |
| Council .....             | \$ 194.86 |
| Legislative .....         | 4,119.40  |
| Postgraduate Course ..... | 2.91      |
| Hospital .....            | 1.85      |
| Executive .....           | 60.02     |
| Scientific Work .....     | 4.05      |
| Miscellaneous .....       | 18.45     |
|                           | 4,401.54  |
| Balance (overdraft) ..... | \$ 402.08 |

13,090.00 Total dues Collected  
1,160.00 Entrance Fees Collected  
\$14,250.00 Dues and Entrance Fees

## EXHIBIT "B"

CASH STATEMENT—  
JOURNAL AND DIRECTORY FUND  
April 21, 1939 through April 15, 1940*Receipts*

|                                                  |             |
|--------------------------------------------------|-------------|
| Cash as per last audit .....                     | \$ 0.00     |
| Earnings from Advertising<br>(Exhibit "E") ..... | \$ 5,722.77 |
| Subscriptions and Misc. Sale .....               | 578.55      |
| From General Fund .....                          | 1,860.26    |
|                                                  | 8,161.58    |
| To be Accounted for .....                        | \$ 8,161.58 |

*Disbursements*

|                                        |            |
|----------------------------------------|------------|
| Postage and Supplies .....             | \$ 418.88  |
| Printing and Plates .....              | 4,953.81   |
| Telephone and Telegraph .....          | 95.19      |
| Salaries .....                         | 2,620.25   |
| Dray and Express .....                 | 17.55      |
| Auditing Books .....                   | 12.50      |
| Photostats .....                       | 3.50       |
| Messenger Service .....                | 8.15       |
| Treasurer's Bond .....                 | 18.75      |
| Repair of Electrotypes .....           | 1.00       |
| Addressograph Service and Repair ..... | 10.00      |
| Copyright, Directory .....             | 2.00       |
|                                        | \$8,161.58 |

CASH BALANCE .....\$ 0.00



EXHIBIT "C"  
CASH STATEMENT—EXHIBIT FUND  
April 21, 1939 through April 15, 1940

| <i>Receipts</i>                  |    |          |          |
|----------------------------------|----|----------|----------|
| Cash as per last audit           | \$ | 0.00     |          |
| Earnings from Technical Exhibits |    | 2,245.70 |          |
| Total Cash to be Accounted for   | \$ | 2,245.70 |          |
| <i>Disbursements</i>             |    |          |          |
| Convention Expense:              |    |          |          |
| Postage and Supplies             | \$ | 7.83     |          |
| Telephone and Telegraph          |    | 83.68    |          |
| Floor Plan and Electrotape       |    | 16.12    |          |
| Sign Painting, etc.              |    | 6.00     |          |
| Exhibit Booth Equipment          |    |          |          |
| (\$200.00 less \$75.00           |    |          |          |
| paid by Princess Isseña          |    |          |          |
| Hotel)                           |    | 125.00   |          |
| Printing                         |    | 16.45    |          |
| Programs                         |    | 85.00    |          |
| Badges                           |    | 70.00    |          |
| Employees' Transportation        |    | 59.27    |          |
| News Service, Cuts               |    |          |          |
| and Mats                         |    | 34.95    |          |
| Proceedings Reporter             |    | 93.40    |          |
| Express                          |    | 2.08     |          |
| Slides                           |    | 4.70     | 604.48   |
| To Entertaining Society:         |    |          |          |
| Volusia Co. Med. Soc.            |    | 45.00    |          |
| Hillsborough Co. Med.            |    |          |          |
| Soc.                             |    | 786.00   | 831.00   |
| To General Fund                  |    | 810.22   | 2,245.70 |
| CASH BALANCE                     | \$ | 0.00     |          |

EXHIBIT "E"  
EARNINGS FROM ADVERTISING  
April 21, 1939 through April 15, 1940

|                  |            |        |
|------------------|------------|--------|
| May, 1939        | \$         | 387.60 |
| June             |            | 506.60 |
| July             |            | 356.08 |
| August           |            | 413.68 |
| September        |            | 332.46 |
| October          |            | 496.26 |
| November         |            | 356.91 |
| December         |            | 490.16 |
| January, 1940    |            | 341.86 |
| February         |            | 607.96 |
| March            |            | 531.98 |
| April            |            | 424.20 |
|                  | \$5,245.75 |        |
| Refund, A. M. A. |            | 477.02 |
| TOTAL            | \$5,722.77 |        |

ASSETS AND LIABILITIES  
April 15, 1940

| <i>Assets</i>                       |             |
|-------------------------------------|-------------|
| Cash in Bank                        | \$11,254.42 |
| General Fund—Accounts Receivable    | 2,420.00    |
| Furniture, Fixtures and Equipment,  |             |
| less depreciation                   | 1,235.64    |
| Library                             | 594.20      |
| Stationery Inventory                | 623.88      |
| Savings: Atlantic National Bank     | 4,288.82    |
| Barnett National Bank               | 8,850.75    |
| Investment (Treasury Bonds)         | 10,178.13   |
|                                     | \$39,445.84 |
| <i>Liabilities</i>                  |             |
| Capital Account                     | \$39,399.64 |
| Hillsborough County Medical Society |             |
| (Society Entertaining)              | 9.00        |
| Journal—Deferred Income             | 37.20       |
|                                     | \$39,445.84 |

The following report of our delegates to the Medical Association of Georgia was read by Dr. Gerry R. Holden:

JOINT REPORT OF DELEGATES TO THE MEETING  
OF THE MEDICAL ASSOCIATION OF GEORGIA

Your delegates were, as usual, given a most hearty welcome. We attended with interest the meeting of the House of Delegates which opened on Monday afternoon, April 22, and later as many of the scientific sessions as possible.

The Medical Association of Georgia devotes much of its time to a consideration of the economic status of its population and to the need for rendering satisfactory service. On Wednesday almost the entire morning was devoted to a symposium on the medical problems of the State, which seemed to be much more acute than those of Florida.

Many counties in Georgia are sparsely populated and the population really suffers from the lack of medical services. In two counties there are no physicians whatsoever; in sixteen counties there are only one or two doctors in each county. Hospital facilities are also inadequate in these sections. A large portion of the population, both white and black, is financially unable to secure medical services as private patients. It is estimated that at least 60 per cent of the population fall into this category, the remaining 40 per cent being able to pay adequate medical fees.

Much time was devoted to the obstetrical situation in Georgia. It was stated that only 18 per cent of the women delivered were attended by physicians. While this statement was questioned, it apparently was approximately correct.

The Medical Association of Georgia is doing a constructive work, both in planning and in acting to extend medical services to those in need.

The scientific portion of the meeting was up to the usual high standard. There were four guest speakers on various portions of the program. Altogether, over 40 Georgia men had places on the program, including those participating in the symposia.

There is not a relative disproportion between this and our own scientific programs. In our program this year we have 24 papers delivered before specialty societies and 17 on the regular sessions of the Association, making a total of 41. The Medical Association of Georgia does not have any adjunct societies and the papers which in our State would be given before specialty groups, and not counted in our regular program, are there made a part of the regular program.

Our visit was interesting and instructive and we appreciate the opportunity extended us to serve as fraternal delegates to Georgia.

Respectfully submitted,  
Gerry R. Holden,  
Homer L. Pearson.

Delegates from the Medical Association of Georgia were recognized.

Dr. W. W. Anderson: We bring you sincere greetings from Georgia. We are always glad to be with you not only for the invaluable things we learn from your Association but for your unbounded hospitality and your Florida sunshine. We are particularly interested in your group meetings of specialists. I think that in time we will all come to do just what you are doing along this line. You are ahead of us in this respect. Again I wish to express my appreciation for enjoying your hospitality.

Dr. C. R. Andrews: There is very little I can add but I would like to express my sincere pleasure in being here with you at this meeting. This is the third year it has been my pleasure to attend and it is always instructive and most enjoyable.

On motion duly seconded and carried the general session recessed to reconvene Wednesday, May 1 at 12 o'clock.

## FIRST SCIENTIFIC ASSEMBLY

The Scientific Assembly convened at 7:00 p. m. Monday, April 29, in the Palm Room of the Tampa Terrace Hotel, with Dr. Walter C. Jones presiding.

The following papers were read and discussed:

1. "Infection of Nasal Accessory Sinuses in Childhood" (lantern slides), Warren W. Quillian, Coral Gables.
2. "Management of the Breast Fed Baby, Including Immunization Procedures", Ludo von Meysenbug, Daytona Beach.
3. "Absorption of Quinine into the Cerebrospinal Fluid of the Fetus in Utero" (lantern slides), H. Marshall Taylor, Lucien Y. Dyrenforth, Jacksonville, and C. B. Pollard, Gainesville.

## SECOND SCIENTIFIC ASSEMBLY

The Second Scientific Assembly was held Tuesday, April 30, at 9:00 a. m., Dr. Herbert E. White presiding.

The following papers were read and discussed:

4. "Impetigo Contagiosa Complicated by Hemorrhagic Nephritis; Case Reports," Henry E. Palmer, Tallahassee.
5. "The Medical Man and the Workmen's Compensation Law," E. Laurence Scott, Ocala.
6. "A Consideration of Climate and Altitude in the Treatment of Hypertension and Myocardial Failure," D. Paul Bird, Lakeland.
7. "Heart Disease" (Symposium)
  - a. "Some Observations on Coronary Occlusion", Roscoe H. Knowlton, St. Petersburg.
  - b. "Correlating History. Clinical and Electrocardiographic Findings in the Diagnosis of Coronary Occlusion," T. Z. Cason, Jacksonville.
  - c. "Aftermath of Coronary Disease," E. Sterling Nichol, Miami.

## THIRD SCIENTIFIC ASSEMBLY

The Third Scientific Assembly was held Tuesday, April 30, at 1:30 p. m., Dr. Leland F. Carlton presiding.

The following papers were read and discussed:

8. "Chronic Empyema" (lantern slides), J. W. Snyder, Miami.
9. "Thoracoplasty Program at the Florida Tuberculosis Sanatorium; Preliminary Report," (lantern slides), L. H. Kingsbury and W. O. Fowler, Orlando.
10. "Therapeutic Evaluation in Cases of Cryptorchidism" (lantern slides), Louis M. Orr, II, and Palmer R. Kundert, Orlando.
11. "Metycaine as a Caudal Anesthetic in Proctologic Surgery; Report of 100 Cases" (lantern slides), Claude G. Mentzer, Miami.
12. "The Syndrome of the Dislocated Intervertebral Disc; Diagnosis and Treatment" (lantern slides), J. G. Lyerly, Jacksonville.

SECOND MEETING OF HOUSE  
OF DELEGATES

The House of Delegates reconvened at 4:30 p. m., April 30, 1940 in the Chamber of Commerce Building, Tampa, President Robinson in the chair. The following delegates answered roll call:

## DELEGATES

ALACHUA—E. H. Andrews.  
 BAY—W. C. Roberts.  
 BREVARD—T. C. Kenaston.  
 BROWARD—R. L. Elliston, E. M. Hendricks.  
 COLUMBIA—No delegate.  
 DADE—W. C. Jones, Jr., M. J. Flipse, W. D. Owens, Kenneth Phillips, J. S. Stewart, H. A. Walker, H. L. Pearson, E. S. Nichol, Franz Stewart.  
 DE SOTO—HARDEE, et al.—I. W. Chandler.  
 DUVAL—C. B. Mabry, S. E. Driskell, R. B. McIver, F. J. Waas, Edward Jelks, L. W. Holloway, N. A. Upchurch, T. E. Buckman.  
 ESCAMBIA—H. L. Bryans, J. N. McLane.  
 FRANKLIN—GULF—No delegate.  
 HILLSBOROUGH—R. S. Torbett.  
 JACKSON—No delegate.  
 LAKE—No delegate.  
 LEE—H. Q. Jones.  
 LEON—GADSDEN, et al.—F. T. Holland, J. K. Johnston.  
 MADISON—No delegate.  
 MANATEE—No delegate.  
 MARION—E. G. Peek.  
 MONROE—No delegate.  
 ORANGE—T. E. McBride, H. A. Day, J. R. Chappell, C. J. Collins.  
 PALM BEACH—L. J. Netto, F. K. Herpel.  
 PASCO—HERNANDO, et al.—W. H. Walters.  
 PINELLAS—J. A. Herring, W. C. McConnell, E. C. MacCordy, W. M. Davis, Grace R. Whitford.  
 POLK—Herman Watson, R. L. Cline, J. R. Boulware, Jr.



PUTNAM—No delegate.  
ST. JOHNS—No delegate.  
ST. LUCIE—OKEECHOBEE, et al.—M. D. Council.  
SARASOTA—M. B. White.  
SEMINOLE—No delegate.  
SUMTER—No delegate.  
TAYLOR—W. J. Baker.  
VOLUSIA—No delegate.  
WALTON—OKALOOSA—C. W. McDonald.  
WASHINGTON—HOLMES—F. M. Watson.  
ASSOCIATION OFFICERS—L. F. Robinson, J. S. Turber-  
ville, J. R. Wells, T. H. Bates, J. W. Taylor, Shafer  
Richardson.

There being a quorum present, the meeting was called to order.

The secretary read a telegram from the president of the Missouri State Medical Association, extending greetings and best wishes for a most inspiring meeting and urging that the delegates to the A. M. A. from Florida be instructed to favor the selection of St. Louis for the 1943 A. M. A. convention. A motion by Dr. W. C. Jones, Jr. that the telegram be turned over to our delegates without instructions prevailed.

The Chairman of Reference Committee No. 1, Health and Education, Dr. W. C. Jones, Jr., was recognized and asked to present the recommendations of that committee.

#### REPORT OF REFERENCE COMMITTEE No. 1

"The Committee recommends that the following resolution, introduced by Dr. L. B. Elliston be accepted and referred to our Committee on Cancer Control for study and development." Doctor Jones moved for adoption of the recommendation. Seconded by Doctor Jelks. Motion prevailed.

#### RESOLUTION

WHEREAS, the study of cancer demands general statistical classification, and

WHEREAS, because of existing irregularities in the records obtained in regard to malignant cases a widespread study of the cancer subject from case histories becomes a difficult one, and

Whereas, because such irregularities tend to discourage the recording of much valuable data causing a great deal of it to be lost,

THEREFORE, BE IT HEREBY RESOLVED, and it is resolved by the Broward County Medical Society in a regular meeting assembled that the President of the Florida Medical Association be requested to appoint a committee for the purpose of studying existing forms presently used for recording case histories and after studying said forms and considering the requirements to be met in such a form to prepare a form for universal adoption throughout the State.

AND IT IS FURTHER RESOLVED that the Florida Medical Association be requested to go on record urging the use of these forms when adopted, by each member, and when completed be filed at central points such as County or Municipal Hospitals under the general heading

*Malignant Cases*, subdivisions indicating the tissue from which the malignancy springs.

Adopted at the regular meeting of the Broward County Medical Society, April 24th, 1940.

(Signed) E. C. Chamberlin, *Secretary*.

"The Committee recommends that the following resolution introduced by Dr. James R. McEachern, not be approved, that the Committee on Tuberculosis and Public Health be not changed." Doctor Jones moved for adoption of the recommendation. Seconded by Doctor Day. Motion prevailed.

#### Resolution Not Adopted

[*WHEREAS, Tuberculosis being only one of the major problems of Public Health in Florida, as one of the four major diseases in Florida, it is the feeling of the Health Officers' section of the Florida Medical Association that there should be a separate committee known as the Tuberculosis Committee:*

*Therefore, Be It Resolved that the House of Delegates be petitioned to create a Committee of Tuberculosis containing six members, one of whom should be engaged in full time Public Health work, and,*

*Whereas, Tuberculosis and Public Health has heretofore been included in one Committee, the Health Officers' Section feels that a Committee on Public Health composed of six members, one to be a full time Health Officer, should be created following dissolution of the Tuberculosis and Public Health Committee as now constituted, and substituting therefor these two committees; That this committee be changed to the Public Health Section of the Florida Medical Association.]*

"The Committee recommends that the following resolution, introduced by Dr. J. S. Stewart, be adopted and referred to the Association's Executive Committee." Doctor Jones moved for adoption of the recommendation. Seconded by Doctor Day. Motion prevailed.

#### RESOLUTION

WHEREAS, there is a possibility of obtaining the 1942 convention of the Southeastern Surgical Association for Miami,

BE IT RESOLVED that the Florida Medical Association extend an invitation to that organization to hold its annual convention in Miami in 1942.

"The Committee recommends the acceptance of the following report, with commendation of the Committee's selection and arrangement of papers." Doctor Jones moved for adoption of the recommendation. Seconded by Doctor Hendricks. Motion prevailed.

#### REPORT OF COMMITTEE ON SCIENTIFIC WORK

During the past year members of this Committee have attended various district meetings and have tried to stimulate as high a type of papers for this session as possible.

At the scientific session all available time is being utilized and for the first time we are having a night scientific assembly at which three papers will be presented. This is more or less a pediatrics symposium and we hope that it may prove of interest and will be largely attended.

The second scientific assembly is related to general medicine and concludes with a symposium on heart disease. The third scientific assembly relates to surgery and the surgical specialties. In the fourth session are papers from the various specialists. This session will be concluded with a clinical pathological conference which is a new feature on the part of this Committee. In all we will have nineteen papers and although all subjects have not been covered we have given as satisfactory a program as it was possible to arrange from the material submitted. Practically all of these papers were taken after a review of the papers in toto, and we definitely feel that it is necessary for the Committee to have a complete paper, or enlarged synopsis of no less than 500 words, in order that it may intelligently select the papers for the Scientific Assembly. The papers which have been submitted to this Committee and not utilized on the State program, will be referred to the councilors of the district and used as they see fit in district meetings.

We trust that you may enjoy your scientific assemblies and find some material which will be of value to you during your stay.

Walter C. Jones, *Chairman*.

"The Committee recommends the acceptance of the following report with favorable commendation." Doctor Jones moved for adoption of the recommendation. Motion prevailed.

#### REPORT OF THE COMMITTEE ON PUBLICATION

During the past year this Committee has reviewed 85 papers; up to this date 61 of these have been published in the Journal. Quite a few necessarily have been referred back for further work, and in so doing, the Committee has only tried to improve the standard of papers appearing in the Journal.

It will be the purpose of the Committee to become more and more strict in its admission of papers to the Journal in order to raise the standard as rapidly as possible. There are now a considerable number of papers in reserve, and it will be impossible to publish all papers which come to the Journal.

All manuscripts must be typewritten, double spaced, and the original copy submitted for review. Duplicate copies will be returned without review.

Results of original work are desired for publication and in case additional editorial help is needed, the same can be obtained by communication with the Editor of the Journal or members of the Committee.

Walter C. Jones, *Chairman*.

"The Committee recommends the acceptance of the following report with favorable commendation." Doctor Jones moved for adoption of the recommendation. Motion prevailed.

#### REPORT OF COMMITTEE ON NECROLOGY

During the past year our Association lost by death the members whose names are listed below:

Gaston Day, Jacksonville  
George H. Day, Sarasota  
John T. Denton, Sanford  
William H. Dodd, St. Cloud  
Paul Eskeberg, Miami  
E. B. Hatch, Miami  
Albert G. H. Holmes, Miami Beach  
Frank E. Kauffman, Clearwater  
J. Lee Kirby-Smith, Jacksonville  
Wilbur A. McPhaul, Jacksonville  
David A. Mills, Zephyrhills

Louis S. Oppenheimer, Tampa  
J. Lewis Pierce, Marianna  
Mathew W. Spearman, Lake City  
Robert Y. H. Thomas, Sr., Jacksonville  
Corbett E. Tumlin, Miami

When possible, obituaries have appeared in the Journal relative to the deaths of these doctors. Tributes have been paid to them in the different communities where they have practiced.

May we at this time, stand in a moment of silence, in reverence and respect to the memory of our departed colleagues.

Respectfully submitted,  
H. A. Barge, *Chairman*.

"The Committee recommends the acceptance of the following report with favorable commendation of the Committee and urges continued cooperation and study." Doctor Jones moved for adoption of the recommendation. Seconded by Doctor Jelks. Motion prevailed.

#### REPORT OF COMMITTEE ON VENEREAL DISEASE CONTROL

The venereal disease control work is being carried on under the supervision of Dr. L. J. Hanchett of the Florida State Board of Health.

Your Committee has not been called upon to do a great deal of publicity work this year. However, we are co-operating in the promotion of this work in every way possible and satisfactory progress is being made.

Respectfully submitted,  
E. T. Sellers, *Chairman*.

"The Committee recommends the acceptance of the following report and that a copy of the report be sent to the Councilor of each district with the recommendation that he use his best efforts to carry out the suggestions in the report." Doctor Jones moved for the adoption of the recommendation. Seconded by Doctor Buckman. Motion prevailed.

#### REPORT OF COMMITTEE ON CANCER CONTROL

The members of your committee have been active throughout the State in presenting discussions on Cancer before medical groups, and various lay meetings when called upon to do so.

Your Committee which serves as the executive committee of the Women's Field Army of the American Society for the Control of Cancer, has cooperated with the officers of this group of women, and heartily endorses the fine work which is being done by this organization in the education of the public about cancer.

We feel that the medical profession, as a whole, should take more interest in the work of this Committee and we would therefore make the following recommendations:

1. That an active Cancer Control Committee be named from each component county medical society, to organize cancer discussions in their own society and to provide speakers for lay education.
2. That diagnostic cancer or neoplastic clinics be organized by the Staff of each hospital along the lines as suggested by the American College of Surgeons.
3. That complete facilities for the treatment of cancer having already been installed in key positions in the State, the profession at large be informed of these facilities that they may refer their cases for early and adequate treatment.



4. Active cooperation of the medical profession with the Women's Field Army in providing public speakers and assist them in the conduct of their annual campaign.

Respectfully submitted,  
James M. Hoffman, *Chairman*.

"The Committee recommends, after striking out two paragraphs that were objected to from the floor, that the balance of the following report be accepted with favorable commendation." Doctor Jones moved for adoption of the recommendation. Seconded by Doctor Jelks. Motion prevailed.

#### REPORT OF COMMITTEE ON TUBERCULOSIS AND PUBLIC HEALTH

This Committee has held during the year two called meetings and five meetings by mail.

The Committee sponsored, in cooperation with the State Tuberculosis Sanatorium, a week of special training in tuberculosis diagnosis and treatment for Negro physicians at the State Tuberculosis Sanatorium. Ten physicians attended.

##### *Strike out two paragraphs.*

*[The Committee, in cooperation with the Graduate Short Course Committee is developing plans for a graduate Seminar for Negro Physicians to be held in Jacksonville, June 24-26. A tentative program is attached and made a part of this report. Twenty-five outstanding Negro physicians of the state have registered in advance. Dr. Howard M. Payne, Negro Tuberculosis Specialist, Howard University, Washington, D. C., will give four lectures on Tuberculosis and conduct one Tuberculosis Clinic. Undoubtedly a more complete report will be a part of the report of the above named committee.]*

*This Committee cooperated with the Florida Tuberculosis and Health Association and Graduate Short Course Committee in securing the services of Dr. David T. Smith, of Duke University, to conduct an institute on Diseases of the Chest. This was held in Daytona Beach June, 1939.]*

The Committee participated in a Work Shop at the 1939 summer school session, University of Florida, in preparation of a plan for a program of health education for the schools of the state. The Bulletin, "Plans for Florida's School Health Program" is attached and made a part of this report.

The Committee worked with a Special Committee appointed by the Florida Radiological Society and many other interested groups in developing a plan for physical examination of school personnel. A part of the annual examination will be an x-ray examination of the chest. Tentative blanks for this examination are attached and made a part of this report. These blanks are under revision at the present time. Details for initiation of this program are being worked out at this time by the State Board of Health and State Department of Education as required in the School Code. It is interesting to note the favorable commendation accruing to Florida as a result of this new program of health education for the schools.

The Committee recommended to the State Welfare Board that all employees in child-caring institutions applying for approval or license be required to have an x-ray examination of the chest annually. As a result of this recommendation a number of institutions have started such programs. The Division of Tuberculosis, State Board of Health, is cooperating with the State Welfare Board and medical directors for the institutions and private practitioners in carrying out this recommendation.

Through the cooperation of the State Board of Health services of the director of the Division of Tuberculosis are now available in a consultant capacity to all state institu-

tions desiring to plan or conduct tuberculosis programs. A number of state institutions have accepted this service and programs have been, or are being, planned along educational and preventive lines.

At the request of this Committee the Florida Tuberculosis and Health Association made available;

1. A copy of "Diagnostic Standards" a pamphlet developed by the Medical Research Committee of the National Tuberculosis Association and American Sanatorium Association to each member of the Florida Medical Association.

2. A copy of "Tuberculosis in General Hospitals", developed by the National Tuberculosis Association, to the superintendent of each general hospital in Florida.

3. The film "Diagnostic Procedures in Tuberculosis" to all medical societies desiring its use. There were ten showings during the year.

4. Films on Tuberculosis designed for the general public to hundreds of lay groups. A film designed specifically for Negroes and another film designed specifically for Spanish-speaking people were distributed to these groups.

The Committee approved a change in policy of the program of the Division of Tuberculosis, State Board of Health. The plan includes case-finding among Negroes, recipients of old age assistance, contact cases and indigent groups selected and approved by County Medical Societies. The Committee approved this change in policy upon recommendation of the director of Division of Tuberculosis and after hearing a report on the results of case-finding surveys.

The Committee cooperated with the State Board of Health and State Tuberculosis Sanatorium in a Tuberculosis Institute for County Health Officers at the State Tuberculosis Sanatorium in December. There was 100% attendance of County Health Officers and in addition, several department heads.

The Committee has continued to function this year as technical advisor for the State Tuberculosis Sanatorium and Florida Tuberculosis and Health Association.

Respectfully submitted,

M. Jay Flipse, *Chairman*.

"The Committee recommends the acceptance of the following report with commendation and recommends continuation of the education of Negro doctors." Doctor Jones moved for adoption of the recommendation. Motion prevailed.

#### REPORT OF COMMITTEE ON MEDICAL POSTGRADUATE COURSE

The 1939 Graduate Short Course was held at Daytona Beach. This was a further experiment insofar as the place of meeting was concerned. The committee had anticipated that a place practically on the ocean would be constantly cool. The entire week, however, was extremely hot with considerable glare. Apparently the consensus was that it would be advisable to hold these meetings in a hotel. The committee therefore decided to hold this year's annual session, June 24-29, at an air-conditioned hotel in Jacksonville. After considering all the facilities available, the George Washington Hotel was selected.

Our financial report shows cash on hand June 1, 1939, \$371.12. In addition there is still \$100.00 on hand as the gift of Dr. R. H. McGinnis. Cash on hand November 1, 1939, \$443.23. A detailed financial statement will be published in the Journal.

During the past year one or more members of the Postgraduate Committee attended each district meeting. The Postgraduate course was discussed. A questionnaire was distributed with the request that each individual present fill out and return. An analysis of the replies to the questionnaire indicated definitely that (1) most of

the men in the state are taking graduate medical education somewhere each year; (2) that a week should be devoted to the course; (3) that no radical changes should be made in the present program; (4) that due consideration should be shown to the general practitioner rather than the specialist.

This year for the first time the Committee is attempting a Graduate Seminar for Negro doctors of medicine at Brewster Hospital in Jacksonville, June 24-26. If the attendance justifies and the Florida Medical Association so desires, this Committee will continue its efforts toward graduate education for Negro doctors.

Financial report is given separately.

Respectfully submitted,

T. Z. Cason, *Chairman*.

"The Committee recommends the adoption of the following report with special commendation on the last two paragraphs which have to do with analyses of death certificates and the publication of the maternal death survey, and that the question of publication of this be referred to the Executive Committee for further action." Doctor Jones moved for the adoption of the recommendation. Seconded by Doctor Buckman. Motion prevailed.

#### REPORT OF THE COMMITTEE ON MATERNAL WELFARE

The Committee wishes to report that during the past year no new major objectives have been attempted. The state wide survey of maternal deaths has continued without interruption and has progressed in a most satisfactory manner.

Again this Committee wishes to thank Doctor Frank V. Chappell, former Director of the Maternal and Child Health Bureau; its present Director, Doctor William H. Ball, and his field workers; and also Doctor Edward M. L'Engle, Director of the Bureau of Vital Statistics, for their continued cooperation and support given to us in connection with this work.

Our program for the past year has been presented to the State Association by contact with each county society through its secretary and each county health unit through its director.

The consulting service for obstetrical complications has been made possible by the Children's Bureau of the United States Department of Labor, through its Advisory Committee of Obstetricians. Physicians who wish to do this work must be qualified obstetricians and must be accepted by the Advisory Committee. Serving on this Committee are Doctor Fred L. Adair, Doctor Robert L. DeNormandie, and Doctor James R. McCord. The Children's Bureau has set aside a fund for this service which is paid through the State Board of Health.

The total number of live births in Florida in 1939 was 31,595 an increase of 500 over 1938. The number of maternal deaths recorded to date is 208. The maternal death rate for the United States in 1938 was 4.4 and the death rate in Florida was 7.5. The provisional death rate for Florida for 1939 is 6.5. The rate for the United States for 1939 is not yet available. Reports indicate that toxemia, septicemia, and hemorrhage are the most common causes of maternal deaths.

There are eighteen county and sixteen health units in the State, which are supervised by the State Board of Health. In 1938 there were only seventeen counties receiving this supervision.

Again this year the Committee wishes to urge each physician who signs a death certificate, to have positive evidence as to whether a pregnancy was a direct or indirect cause of death before signing it.

We, the Committee, recommend that this survey of maternal deaths be made permanent, and that after five years the result of this survey be printed in book form. This procedure is used in many states, and by its extensive supply and comparison of facts will serve to lower the maternal death rate simply by education.

Ferdinand Richards, *Chairman*.

"The Committee recommends the adoption of the following report with favorable commendation." Doctor Jones moved for adoption of the recommendation. Seconded by Doctor McBride. Motion prevailed.

#### REPORT OF THE COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

Your Committee has not been very active during the past year due to the fact that we have not received instructions from the Executive Committee to proceed with our investigation of the hospitals in the state, which was started in 1938. This investigation was relative to the by-laws and constitution of those hospitals and particularly towards any contract which hospitals may have with doctors on the staff. We reported at the last meeting of the House of Delegates on May 1, 1939 that there were a number of hospitals employing physicians under contract but we were instructed by the Executive Committee of the State Association not to take any action against these hospitals until further notified, and as yet we have not been advised to proceed.

Your Committee was of assistance to the State Association in furnishing a complete list of hospitals, sanitariums and related institutions in the state. There are ninety-seven of these institutions as are listed in the Florida Medical Directory of 1940. Inclusion of any institution in this list indicates that no evidence of irregularity or unsafe practice in that institution has come to the attention of the Committee on Medical Education and Hospitals.

We were also of some assistance to the American Medical Association in having the registered hospitals of the State of Florida included in the A. M. A. Annual Census of Hospitals.

Respectfully submitted,

J. R. Chappell, *Chairman*.

"The Committee recommends the adoption of the following report with favorable commendation and that the Committee on Legislation and Public Policy be requested to study the preparation of a bill for compulsory vaccination against smallpox and diphtheria, for possible presentation at the next session of the legislature." Doctor Jones moved for adoption of the recommendation. Motion prevailed.

#### REPORT OF COMMITTEE ON CHILD HEALTH

During the past twelve months the larger cities of the state have been provided with pediatric and public health nursing very well through city health services and voluntary health agencies. The latter include child welfare activities of the Junior League; the Children's Home Society of Florida (with branches at Jacksonville, Miami, Pensacola and Lakeland); city and county hospitals with their out-patient facilities. There is no adequate program for medical social service. Consequently, there exists a lack of co-ordinated effort and follow-up care which would render more effective the service now being offered.

In rural areas and small towns of Florida no general



policy relative to child health is followed. The program of parent-teacher organizations and isolated services rendered by individual physicians in improvement of the health status of the school child is an exception to this general statement. The pre-school age and the period of adolescence is neglected. Need for adequate funds to provide personnel (nurses and physicians) is a great handicap to the accomplishment of any state-wide program.

During 1939 a survey reveals that 56 per cent of the white and 96 per cent of the colored school children in Miami have been vaccinated against smallpox. It is significant that the white parents must sign consent-slips while the colored children are routinely vaccinated by the city health organization without question. This implies that 44 per cent of the white parents are too disinterested or apathetic concerning this important phase of child health and preventive care to give their consent.

Existing health agencies can provide cooperation, instruction and advice in the formation of a good school health program. This can be done without necessarily antagonizing the private physician. Much education is needed in conservation of health and prevention of disease among children. Great credit is due the efforts of Doctor T. Z. Cason and his Committee which provides the annual Medical Postgraduate Course. The emphasis upon pediatric and obstetrical training in the curriculum is reflected statistically in an improved morbidity and mortality rate among children of Florida.

Infant mortality statistics recently issued by the U. S. Bureau of the Census give the following information:—

1. Infant mortality rate for 1938 in the U. S. was 51.0 per 1000 live births, (the lowest on record for the United States 1915-1938). In Florida during 1938 there were 58 deaths per 1000 live births, representing a decrease from 60 deaths per 1000 live births in 1937.

2. More than half (54 per cent) of infant deaths in 1938 were in rural areas; less than half (46 per cent) in cities of 10,000 or more population.

Much remains to be done in conserving the health of Florida children. The recent White House Conference on Children in a Democracy (January 1940) indicates an awakened interest on the part of the Federal government in the welfare of these future citizens. Cooperation of state, local, and Federal agencies is needed for proper development of an adequate program for Florida.

Your Committee makes the following recommendations:—

1. Increased availability of preventive and curative health service through expansion of existing agencies and facilities.

2. Pediatric consultation service when desired by general practitioners in their care of children. This can be accomplished in cooperation with the Florida Pediatric Society.

3. Development of a program for the control of communicable disease. This might include sponsorship of compulsory vaccination for school children against smallpox and immunization against diphtheria for pre-school as well as school groups. This Committee feels that this work should be done by the local physician when possible.

4. Nutrition services and well-baby conferences.

5. Encouragement of the general physician to attend periodic courses of intensive instruction in child care, by making available scholarships from private or public funds. Such expenditures may be safeguarded by a control committee and placed on an award basis.

Warren W. Quillian, *Chairman*.

#### References:

1. The Child, IV, No. 8:207 (Feb. 1940) (U. S. Dept. Labor.)

The chairman of Reference Committee No. 2, Public Policy, Dr. H. A. Walker, was recognized and asked to present the recommendations of that committee.

#### REPORT OF REFERENCE COMMITTEE No. 2

"The Committee recommends the approval of a proposed bill as set forth in the resolution submitted by Dr. T. E. McBride, to be introduced in the Legislature, the enacting clause of which is as follows." Doctor Walker moved for adoption of the recommendation and that the bill be referred to the Association's Committee on Legislation and Public Policy. Motion prevailed.

#### PROPOSED BILL

An act to authorize and direct hospitals, morticians, undertaking establishments and others having in their possession dead human bodies not claimed by relatives, fraternal orders, or other interested parties within a reasonable time to deliver said bodies to the component medical societies of the respective counties, or their representatives, providing for the removal, use and disposition of such bodies, and requiring certain records to be kept relative thereto.

"The Committee recommends the approval of the following report." Doctor Walker moved for adoption of the recommendation. Seconded by Doctor Buckman. Motion prevailed.

#### REPORT OF COMMITTEE ON MEDICAL ECONOMICS

First we must consider the report of Doctor J. C. Vinson presented at the last meeting of the House of Delegates. He reported that a copy of the plans, for the establishment of the Contact Bureau of the Florida Medical Association, had been given to each member according to the instructions of the first meeting of the House of Delegates. Since you have had a copy of this report, with which you are all familiar, I will not embody it in this report.

The motion was made by Doctor H. A. Day, at this time, that it be referred back to the Economics Committee for further consideration, seconded by Doctor Sellers. A suggested amendment to Doctor Day's motion was that this plan be referred to the Economics Committee, Executive Committee and Public Relations Committee. The amendment was accepted by Doctors Day and Sellers. It was unanimously carried.

On January 21, in Jacksonville, at the Pre-Convention Meeting, these three committees met and gave due consideration to this subject. The following resolution was made and passed.

Resolution: That we beware of the establishment of a Contact Bureau, since it is held impracticable. We recommend that no further action be taken on this matter by the House of Delegates. Passed and signed by the following members of these three committees: Leigh F. Robinson, *President*; J. S. Turberville, *President-elect*; *Executive*—Gilbert S. Osincup, chairman, Louie M. Limbaugh, Joseph S. Stewart, William C. Thomas, Shaler Richardson; *Medical Economics*—Harrison A. Walker, chairman, Edwin H. Andrews, Meredith Mallory; *Public Relations*—J. Ralston Wells, chairman.

It is also a further report and policy of the Committee on Medical Economics that since the economic status of the A. M. A. and profession generally is in the state of indecision that it is, that our Committee make no resolution or set a definite program at this time. We, however, are continuing to consider duly and logically the economic problems presenting themselves to the Profession.

Respectfully submitted,  
Harrison A. Walker, *Chairman*.

"The Committee recommends the approval of the following report, except that no recommendation be made to appropriate money for the use of the committee and that the question of appropriations be referred to the Executive Committee." Doctor Walker moved for adoption of the recommendation. Seconded by Doctor Day. Motion prevailed.

#### REPORT OF THE COMMITTEE ON PUBLIC RELATIONS

For the past year our Committee has been more or less inactive due to several causes. There seems to have been a decided reluctance on the part of our members to write articles. Appeals have been made by each of the Committee members through their component societies. At times papers have been promised but the promises were not adequately fulfilled and at other times various men have been too busy to make the trip necessary to the radio station. The radio station at Gainesville has been very seriously crippled in its administration due to the present Governor vetoing the appropriation for the year. Incidentally, the station is still carrying on, funds having been found through one source or another. The broadcasting time, through the director of W. R. U. F., Major Garland Powell, is still available to the Association.

The idea of dramatizing a paper, as first suggested by our former chairman, Dr. Roy Holmes, seems to be excellent. Papers written by various of our members could be dramatized by one of the Staff of the radio station; returned to the Committee for correction and approval; then put on a permanent record and this record becomes the property of the State Medical Association. These records could then be used by any local radio station. It is our idea that records such as this be made, add to them from time to time and have a circulating library from which records could be sent to various local stations. There are a number of stations throughout the State that would, through the request from various members, put these records on the air. Each record would contain two 15 minute dramatizations at a cost of approximately \$16 per record. If the subjects were well planned there could be a definite hookup in the series that would carry the public interest.

*This paragraph referred to Executive Committee:*

*[Money voted, by the Executive Committee last year, \$150.00, has not been utilized due to lateness in the year of the request and approval. Therefore, your Committee requests that a sum of money not less than \$250 and not more than \$350 be made available in this next year for the purpose of securing permanent records. This would give the Association from 16 to 20 records for the year 1940-1941.]*

We feel that at times the Committee has not been fully utilized in promoting public relations. We suggest that the President from time to time instruct this committee to explain and propagandize the aims of organized medicine to such bodies as Chambers of Commerce, Women's clubs, lay bodies which contemplate building,

equipping or maintaining hospitals, or public health centers, this aid not to replace local county organizations but to add weight to their aims and arguments.

Respectfully submitted,  
J. Ralston Wells, *Chairman*.

"The Committee recommends the approval of the following report." Doctor Walker moved for adoption of the recommendation. Motion prevailed.

#### REPORT OF THE ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

The Advisory Committee, together with Dr. Leigh Robinson, met with the President of the Woman's Auxiliary, Mrs. L. C. Ingram, and her board, in June. The meeting was held at Daytona Beach. As a result of this meeting the following charges were sent to each county auxiliary president by Doctor Robinson:

- I. Hold regional auxiliary meetings at the same time and place of the state district medical meetings as near as possible.
- II. Hold bigger and better third annual Health Institute day.
- III. Consider starting as a state objective, a medical school scholarship fund for a doctor's widow's son, or some deserving member of a doctor's family, this to be voted on at the next state medical meeting, in Tampa; a small amount to be prorated from each member.
  1. Continue to publicize as widely as possible the necessity of periodic examinations of domestic servants, as well as periodic health examinations for all.
  2. Hold yourself in readiness to cooperate 100 per cent with the chairman of the legislative committee.
  3. See that your organization becomes informed about socialized medicine, and distribute literature on this subject. Literature may be obtained.
  4. Cooperate with the Tuberculosis Association, particularly in the Christmas seal sale.
  5. Cooperate with the Southern Jane Todd Crawford Memorial scholarship fund.
  6. Secure A. M. A. broadcasts over your local station and urge the schools of your county to permit the pupils to listen and make use of them in their science classes.
  7. Continue diligently to distribute the magazine Hygeia.
  8. Cooperate with the Cancer Field Army.
  9. Prepare an interesting exhibit for the state medical meeting.
  10. Secure the health education program, 1940-41, of the National Auxiliary from Mrs. V. E. Holcombe, 1635 Quarrier Street, Charleston, West Virginia.

Through Mrs. Ingram's efforts, the district meetings have served as a meeting place this year. Two district auxiliaries and one new county auxiliary have been organized this year.

The educational work that the state and national auxiliaries have been undertaking in the past is being done on so much larger scale by the State Wide Public Health Committee that it is the opinion of your committee that we should concentrate some energy in assisting to direct the thoughts, work and publicity of these lay committees, through our members and sympathetic women's organizations. It has been our policy in the past to too frequently remain silent.

Respectfully submitted,  
Gordon H. Ira, *Chairman*.



"The Committee recommends the adoption of the following resolution, introduced by Dr. H. L. Bryans, and that the president appoint a special committee to investigate the matters contained in this resolution and that the special committee make its recommendations to the Committee on Legislation and Public Policy." Doctor Walker moved for adoption of the recommendation. Motion prevailed.

#### RESOLUTION

WHEREAS, The Optometrists' Law of the State of Florida obviates the employment of optometrists by lay organizations or corporations for professional service, and

WHEREAS, These agencies are circumventing this law by the employment of physicians licensed in the State of Florida regardless of their qualifications as oculists or ophthalmologists, and

WHEREAS, Such practice is a distinct lowering of the standards of medical ethics and an unfair practice to the citizens of this state,

THEREFORE, Be it resolved, that the Escambia County Medical Society go on record as disapproving this practice and instruct its delegates to the next meeting of the Florida State Medical Association to request the State Association to propose suitable legislation to the Legislature of the State of Florida to curtail such practice in the profession and to provide certain standards of qualifications and training for all physicians specializing in ophthalmology and its branches.

"The Committee recommends that the following resolution, introduced by Dr. M. D. Council, be approved and referred to the Committee on Legislation and Public Policy for action." Doctor Walker moved for adoption of the recommendation. Motion prevailed.

#### RESOLUTION

To the House of Delegates of the Florida Medical Association. From the St. Lucie-Okeechobee-Indian River-Martin Society, authorized in regular session (Dec. 21, 1939).

RESOLVED, that the Legislative Committee of the Florida Medical Association use its influence toward passage of a Bill by the State Legislature requiring a tax collector, before issuing an occupational license to practice medicine in Florida, to ascertain whether or not the applicant has had his license to practice medicine in the State recorded with the Clerk of Court in the County in which he is practicing and, if same has not been done, to prevent him (the tax collector) from issuing such occupational license.

"The Committee recommends that the following report be approved." Doctor Walker moved for adoption of the recommendation. Motion prevailed.

#### REPORT OF COMMITTEE ON INTER-RELATIONSHIP

There has been a canvass of many dentists, druggists, and nurses association heads who have stated that they will be willing to submit any problem that might come up to us for aid, adjustment, or correlation.

Through several officers of the Florida Pharmaceutical Association your chairman has been appointed a mem-

ber of the United States Pharmacopoeial Revision Committee which will meet in Washington on May 13, 14, 15, 1940.

The Florida Pharmaceutical Association has asked our aid in an educational program to be launched some time later this year for the purpose of educating the physician in becoming acquainted with the United States Pharmaceutical products that can be manufactured or bought by the pharmacist at such a price as to retail for 25 to 75 per cent less than corresponding products detailed to us (and I am sorry to say used by us) by many of the leading pharmaceutical houses in the country.

The result of the above practice is to increase the cost of the medication to the patient and decrease the pharmacist's income when he dispenses such preparations on our prescriptions.

This Committee recommends that this educational program be endorsed by the Florida Medical Association.

E. C. Swift, *Chairman*.

"The Committee recommends the adoption of the following report." Doctor Walker moved for adoption of the recommendation. Seconded by Doctor Day. Motion prevailed.

#### REPORT OF COMMITTEE ON STATE CONTROLLED MEDICAL INSTITUTIONS

Three facilities maintained by the State come under the heading of Medical institutions, viz: The State Hospital at Chattahoochee; the Home for Feeble-minded and Epileptics at Gainesville and the State Tuberculosis Sanatorium near Orlando.

The State Hospital, with Dr. J. H. Therrell as Superintendent and Dr. Ralph E. Stevens as Chief Physician, has a staff of fourteen physicians resident, and two on the visiting staff, Dr. J. C. Davis on Urology and Dr. J. G. Lyerly, Neurosurgery. There is an approved nurses' training school with twenty-four graduate nurses and sixty-eight undergraduates. Affiliates are accepted from other schools in the state.

This institution's clinical laboratory has recently been approved by the American Medical Association for training technologists. Each year there is held a psychiatric institute for graduate nurses of the state. Last year's attendance was fifty. Admission rate of patients is approximately ninety per month. Total admissions during the year 1939 were 1002.

The Committee is of the opinion that another institution for the treatment of insane persons should be built at some point in the southern part of the state. This would relieve congestion at Chattahoochee and would permit a better segregation of patients susceptible of cure or betterment at a more accessible location.

The Home for Feeble-minded and Epileptics, located at Gainesville, is under the very able direction of Dr. J. Maxey Dell.

This institution owns about 3000 acres of land, of which approximately 500 acres are under cultivation. It owns and operates its own laundry, cold storage plant, ice plant, water works and dairy. There are about forty-five buildings, including a new modernly equipped infirmary of forty-five beds.

Normal capacity of this institution is 550 patients. There are approximately 500 other children in the state at large who should now be in this institution for care and treatment.

I regret very much that I have not been able to include a report on the Tuberculosis Sanatorium near Orlando. I waited too long to ask for information that would have constituted such a report. I do wish to state that I am informed that this institution is very competently conducted and is a credit to our state.

We need additional capacity for the care of the tuberculous.

Respectfully submitted,  
Geo. A. Dame, *Chairman*.

"The Committee recommends the adoption of the following report." Doctor Walker moved for adoption of the recommendation. Motion prevailed.

#### REPORT OF COMMITTEE ON LEGISLATION AND PUBLIC POLICY

At the last session of the legislature we sponsored and got passed the Basic Science Bill.

We lent our support to some other bills affecting public health. We used our influence to defeat several bills that were very detrimental to the public health of our citizens and tourists, and obnoxious to the medical profession.

Your chairman read, and consulted the members of the legislature on, about three hundred bills introduced. Some of these bills were amended so as not to be detrimental to the public health; others defeated outright.

On our accomplishments we wish to thank the entire membership of the Association for their untiring and wholehearted support. Without exception everyone called on gave unsparingly of his time and finances to assist us. Especially, we would like to pay tribute to the late Dr. C. E. Tumlin of Miami for his efforts. We also wish to thank those members of the House and Senate who assisted us.

Last but not least, we wish to acknowledge and again thank our legal advisor and his assistants for their hard work and untiring assistance to us in our program, for without him not only would our bills have failed of passage, but many other bills, very detrimental to the medical profession and public, would have passed.

Respectfully submitted,

H. A. Day, *Chairman*.

"The Committee recommends the adoption of the following substitute resolution, for the one introduced by Dr. Edward Jelks." Doctor Walker moved for adoption of the recommendation. Motion seconded.

Doctor Buckman: The substitute resolution differs fundamentally from the resolution read before the House yesterday.

Question from the floor as to why the substitute resolution was presented by the reference committee.

Doctor Jelks: I am very glad to explain why I agreed to the substitute resolution. The original resolution was unanimously approved by the delegates from the Duval County Medical Society. We came here instructed to put this matter before you in the form of a motion, not exactly as presented yesterday, but not as we did it today. Your reference committee and the other members present talked this over about two hours this morning and it was decided that the substitute resolution would carry greater possibility of getting through the necessary channels and would accomplish the main things desired.

Motion to table the substitute resolution made and seconded. Motion to table lost by standing vote of 12 for and 27 against.

#### Discussion on original motion:

Doctor Flipse: In regard to this motion, I feel as Doctor Buckman does and believe that we should ask for five physicians. I am, therefore, opposed to the substitute resolution and in favor of the original resolution as read yesterday.

Doctor Day: I was on this committee. I want you to know that the committee favors the doctors being on the State Board of Health but it must first pass through the legislature and then be voted at a general election. If

we don't recognize the lay organizations that work with the public health committees we will not get anywhere.

Doctor Owens: With this substitute resolution we are trying to get something we do not particularly want.

Doctor Richardson: I am a member of the State Board of Health and feel that either one of these suggestions would be an improvement on the present system. In my opinion a board consisting of two M. D.'s, one dentist, one druggist and one layman would be much better than the other suggestion. Being familiar with many problems that confront the Board of Health, I believe that a business man as a member would be helpful to the Board in conducting its affairs. The State Pharmaceutical Association, through one of its members who is now on the State Board of Health, has been very helpful in solving certain problems. A representative from the Dental Society would certainly be helpful. If we could have two M. D.'s, one D. D. S., one pharmacist, and a layman with business ability, it would be a better balanced Board than five physicians and the Attorney General.

Doctor Peek: A mixed board could ask for finances a great deal better than five doctors.

Doctor Upchurch: I have had an opportunity to study this problem and feel the Board should be composed of five doctors.

The question was called for. By rising vote the motion carried by a large majority, there being only 19 opposing votes, so the Committee's recommendation to adopt the substitute resolution prevailed.

#### SUBSTITUTE RESOLUTION

WHEREAS, the Committee recognizes that an improvement in the organization of the State Board of Health is advisable to protect the Public Health status of the people of the State of Florida by disassociating the Board of Health from political influence.

BE IT RESOLVED that the House of Delegates vote that the Florida Medical Association assist and cooperate with the State-Wide Public Health Committee and allied organizations, interested in Public Health in securing a Constitutional amendment for the reorganization of the State Board of Health.

BE IT FURTHER RESOLVED that the House of Delegates shall instruct the Committee on Legislation and Public Policy to have prepared for presentation to the next session of the Legislature of the State of Florida, a resolution providing for the reorganization of the State Board of Health, including the following provisions:

1. To arrange for a Constitutional Amendment to be submitted to the electorate.
2. To provide for the appointment by the Governor of a State Board of Health, consisting of two Doctors of Medicine, said Doctors of Medicine to be selected from a list of nominees submitted to the Governor by the Executive Committee of the Florida Medical Association; one dentist, one pharmacist, recommended by their respective organizations, and one layman. The State Health Officer shall serve as Secretary of the Board. The State Board of Health so appointed shall have complete authority to employ the personnel of the Department of Health of the State of Florida, to outline the work of such department, and to direct the expenditures of all monies appropriated for state health activities and also any additional monies made available from other sources.

#### Original resolution not adopted:

[BE IT RESOLVED that the House of Delegates shall instruct the Committee on Legislation and Public Policy to have prepared for presentation to the next session of the Legislature of the State of Florida, a resolution providing for the reorganization of the State Board of Health, including the following provisions:



1. *To arrange for a Constitutional Amendment to be submitted to the electorate.*

2. *To provide for the appointment by the Governor of a State Board of Health, consisting of one Doctor of Medicine from each Congressional District in the State of Florida, said doctor of medicine to be selected from a list of nominees submitted to the Governor by the Executive Committee of the Florida Medical Association. The Attorney General of the State of Florida shall also be a member of said Board. The State Health Officer shall serve as Secretary of the Board. The State Board of Health so appointed shall have complete authority to employ the personnel of the Department of Health of the State of Florida, to outline the work of such department, and to direct the expenditures of all monies appropriated for the state health activities and also any additional monies made available from other sources.]*

The chairman of Reference Committee No. 3, Finance, Dr. Shaler Richardson, was recognized and asked to present the recommendations of that committee.

#### REPORT OF REFERENCE COMMITTEE NO. 3

"The Committee recommends that changes in the By-Laws as recommended by the Executive Committee at the first meeting of the House of Delegates be approved."

Doctor Richardson moved that Chapter III, Section 8 be amended by adding: "Delegates' terms shall begin on January 1 following election." Motion seconded and carried.

Doctor Richardson moved that Chapter III be amended by adding Section 17 as follows: "Section 17. A delegate whose name has been placed on the roll of the House of Delegates shall remain a delegate of the body which he represents throughout all sessions, until final adjournment of its annual meeting, and his place shall not be taken by any other delegate or alternate." Motion seconded. Question from the floor requesting explanation.

Doctor Richardson: The principle reason for Section 17 is that many of the members of the House of Delegates come to the first meeting and are familiar with the things that are to be acted upon the following day, and the next day might turn the duties over to someone else who is not familiar with the things that have transpired in the House of Delegates the preceding day.

The question was called for and the motion carried.

Doctor Richardson moved that Chapter V, Section 3 in the third sentence be amended by deleting the words "the second" and inserting in lieu thereof "a". Motion seconded and carried.

Doctor Richardson moved that Chapter V, Section 4 in the third from the last sentence be amended by deleting the words "the second" and inserting in lieu thereof "a". Motion seconded and carried.

Doctor Richardson moved that Chapter VII, Section 2 at the end of the first paragraph be amended by deleting the words "and shall render a report of its actions to the Second General Session." Motion seconded and carried.

Doctor Richardson moved that Chapter III be amended by adding a new section as follows: "Section 18. There shall be at least three reference committees to aid the House of Delegates: No. 1, Health and Education; No. 2, Public Policy; No. 3, Finance and Administration." Motion seconded and carried.

Doctor Richardson moved that Chapter III be amended by adding a new section as follows: "Section 19. These committees shall be appointed by the president from the members of the House of Delegates. Each committee shall consist of five members of which three shall constitute a quorum. These appointments shall be announced by the president at the first meeting of the House of Delegates, following the adoption of the minutes of the previous meeting." Motion seconded and carried.

Doctor Richardson moved that Chapter III be amended by adding a new section as follows: "Section 20. One of the members of each reference committee shall be named as chairman by the president." Motion seconded and carried.

Doctor Richardson moved that Chapter III be amended by adding a new section as follows: "Section 21. Regular committee reports, resolutions, measures and propositions presented to the House of Delegates shall be referred to the appropriate committee, which committee shall report to the House of Delegates before final action shall be taken, unless otherwise ordered by a vote of two-thirds of the members of the House of Delegates." Motion seconded and carried.

Doctor Richardson moved that Chapter III be amended by adding a new section as follows: "Section 22. Each reference committee shall, as soon as possible after the adjournment of each session or during the session if necessary take up and consider such business as may have been referred to it and shall report on the same at the next session or when called on to do so." Motion seconded and carried.

Doctor Richardson moved that Chapter III be amended by adding a new section as follows: "Section 23. The chairman of reference com-

mittees shall announce in the House of Delegates or by postings on bulletin board the time and place members of the Association may be heard at reference committee meetings when controversial questions are debated." Motion seconded and carried.

#### REPORT OF EXECUTIVE COMMITTEE

The first meeting of the Executive Committee was held May 3, 1939 at Daytona Beach. It was decided to have special badges for all members of the House of Delegates at the next meeting. It was suggested that the by-law concerning credentials and the seating of official delegates be enforced. A tentative budget for expenses during the ensuing year was approved, on a similar basis as for the preceding year.

The second official meeting of the Executive Committee was held June 21, 1939 at Ponte Verda. Mr. Francis P. Whitehair was engaged on a retainer fee as counsel to assist in drafting a basic science bill and have it introduced in the legislature. Since Mr. Whitehair is familiar with legislative procedure, he was to render service and advice in securing the passage of a basic science law and to aid in defeating proposed bills which, in the minds of the doctors, would be detrimental to public health.

A recommendation of our delegates to the A. M. A., brought before the last meeting of the House of Delegates at Daytona Beach, which had been referred to the Executive Committee was approved by your Committee. The time of Dr. Herbert L. Bryans' term was extended to include the calendar year of 1940 and the term of Dr. Meredith Mallory was extended to include the calendar year of 1941. Hereafter when delegates to the A. M. A. are elected their terms of office are to be designated by calendar years and not by fiscal years. The reason set forth by our delegates were approved on the basis of information given. A delegate who takes office immediately after the annual convention of our Association does not have his name given to the A. M. A. until a short time before the A. M. A. House of Delegates convenes. Therefore, he is not considered for committee appointments and does not have time to familiarize himself with the duties of his office and make arrangements to attend the meeting, as there is insufficient time between our meeting and the meeting of the A. M. A. Under the new arrangement the newly elected delegate will take office January 1 and his name will be submitted to the A. M. A. six or eight months in advance. It will, therefore, give Florida a much stronger representation. It was also decided to notify our delegates to the A. M. A. of all meetings of our standing committees throughout the year, in order that they may glean information concerning the activities of the Association, which might be helpful to them in functioning at the A. M. A. House of Delegates meeting.

The next meeting of the Committee was held September 27, 1939 at Lakeland. Action was taken, authorizing the Association's treasurer to transfer \$1,800.00 from the general fund to the emergency fund in order to reimburse Mr. Francis P. Whitehair for his services, expenses and fee.

The recommendation of Dr. H. D. Van Schaick at the last meeting of the House of Delegates was referred to your Committee and, on motion, the idea of a mental hygiene society was approved and your Committee offered aid, as far as possible.

On recommendation of the Alachua County Medical Society, Dr. Matthew H. DePass was elected to Honorary Membership. On recommendation of the Pinellas County Medical Society, Dr. Emil Lustig was approved for Honorary Membership. On recommendation of the Dade County Medical Society, a refund of \$10.00 for 1939 dues and \$10.00 entrance fee was authorized in connection with the late Dr. Paul Eskeberg. The refund was made to the Dade County Medical Society. A request from the Dade County Medical Society for

\$200.00 to be matched with a like amount from the Association's funds in connection with medicolegal aid was approved.

On recommendation of the Hillsborough County Medical Society the official dates for the 1940 annual convention in Tampa were set for April 29, 30 and May 1. at the request of President Robinson, Dr. Gerry R. Holden appeared at the Committee meeting with a recommendation for three reference committees to serve in connection with meetings of the House of Delegates. The plan was approved and a suggested amendment to the by-laws, to recognize officially three reference committees, will be presented with other recommendations for amendments to the By-Laws.

A schedule of meetings for the 1940 convention was approved, as published in your official program. You will note a number of changes which your Committee feels will give more consideration to special groups and provide additional time for scientific sessions, allowing an increase in the number of essayists appearing on the program.

The next meeting of the Executive Committee was held January 21, 1940 in Jacksonville. Two applications for entertaining the Association's annual convention for 1941 were presented—Dr. Herbert L. Bryans representing the Escambia County Medical Society, for Pensacola; and Dr. Robert B. McIver representing the Duval County Medical Society, for Jacksonville. Your Committee, after careful consideration of hotel facilities and other important details, recommends that the 1941 annual convention of the Association be held in Jacksonville.

On recommendation of the Dade County Medical Society, Dr. J. O. Barfield was elected as an honorary member for 1939. On recommendation of the Dade County Medical Society, Drs. George H. Day and Benjamin F. Eckman were elected to Honorary Membership. On recommendation of the Pinellas County Medical Society, Dr. Ludlow Lambdin was elected to Honorary Membership.

Your Committee authorized the appointment of three delegates from our Association to attend the U. S. Pharmacopoeial Convention in Washington, D. C., May 14 and 15, 1940. Our Association, as a corporation, is entitled to three delegates. Communications from Dr. P. A. Foote of the University of Florida School of Pharmacy, a letter from Dr. Paul N. Leech of the A. M. A., together with copies of editorials appearing in the A. M. A. Journal, were studied by your Committee and the secretary was authorized to sign credential papers in connection with the appointment of our three delegates.

On recommendation of Dr. J. Ralston Wells, chairman of the Association's Committee on Public Relations, the expenditure of \$150.00 was set up, from which invoices are to be paid in connection with purchasing radio recordings of doctors' addresses as broadcasted.

Three years ago, on recommendation of your Executive Committee, the House of Delegates in session at St. Petersburg took official action to employ a full time managing director. To finance this new venture it was necessary to have faith that the additional efforts would increase the Association's income, or be willing to underwrite approximately \$6,000.00 for the past three years from savings on hand.

The cost of additional office space for the past three years amounted to \$1,500.00. A new mimeograph was purchased for \$370.00. An extra \$2,000.00 was allowed the Association's Committee on Legislation and Public Policy. A new addressograph with plate cabinet was purchased for \$430.00 and a number of smaller items of equipment were purchased. The enlarged program necessitated additional postage and supplies which amounted to a considerable sum. For the past three years there was an extra expense of well over \$10,000.00 above the usual budget.

The picture of additional expenses is given to em-



phasize the favorable results that have been obtained, notwithstanding the extra load carried. Your Committee is gratified to report officially that the income for the past three years, with a full time managing director, is \$1,682.63 in excess of expenditures for that period. Notwithstanding the extra cost of your Association's enlarged program of activities, you will find in your treasurer's financial report this year that there is \$1,682.63 more cash in the treasury than there was shown in his financial report at St. Petersburg in April, 1937.

The following amendments and additions to the Association's By-Laws have been approved by your Committee, with the recommendation that they be read at this time and officially accepted and passed at tomorrow's meeting of the House of Delegates. [See preceding actions for text.]

The meetings of the Executive Committee during the past year have been well attended and I wish personally to express deep appreciation to the members of this Committee for their splendid cooperation and interest in performing the tasks required by the activities of the Committee. The membership of the Committee is widely separated throughout the state and it was only through active interest in the affairs of the Association and at personal expense of time and money that the Association has received the benefit of a real contribution from them.

Respectfully submitted,  
Gilbert S. Osincup, *Chairman.*

"The Committee recommends that a charter be issued to the Madison-Suwannee County Medical Society." Doctor Richardson moved for adoption of the recommendation. Motion prevailed.

"The Committee recommends the adoption of changes in the By-Laws as recommended by the Council in yesterday's meeting of the House of Delegates."

Doctor Richardson moved that Chapter XI be amended by adding a new section as follows: "Section 14. The House of Delegates shall assign all counties not covered by Section 10 to some nearby county medical society on recommendation of the Council, such county society to aid and supervise in public health and medical questions in the counties so assigned, the same as for the county or counties named in its charter, until these counties are organized separately and hold their own county medical society charters." Motion seconded and carried.

Doctor Richardson moved that Chapter XI of the By-Laws be amended by adding a new section as follows: "Section 15. Each county medical society shall be required to have a minimum of three members to retain its charter. Should the number of members of any county medical society fall below a total of three, it shall be the duty of the Council to make an effort to increase the membership of that county medical society to at least the minimum requirement. If the efforts of the Council fail

and a county medical society's membership falls below the minimum of three, such society shall automatically lose its charter." Motion seconded and carried.

"The Committee approves the following recommendation of the Council." Doctor Richardson moved for adoption of the recommendation. Motion prevailed.

#### RECOMMENDATION OF THE COUNCIL

That county medical societies take over the supervision of unorganized counties, as authorized in Chapter XI, Section 14 of the By-Laws, as follows:

To Escambia County Medical Society—Santa Rosa County.

To Jackson County Medical Society—Calhoun County.

To Columbia County Medical Society—Baker and Hamilton Counties.

To Taylor County Medical Society—Dixie and Lafayette Counties.

To Alachua County Medical Society—Bradford, Gilchrist and Union Counties.

To Marion County Medical Society—Levy County.

To Duval County Medical Society—Clay and Nassau Counties.

To Volusia County Medical Society—Flagler County.

To Lee County Medical Society—Collier and Hendry Counties.

To Orange County Medical Society—Osceola County.

To Lake County Medical Society—Sumter County.

#### REPORT OF THE COUNCIL

Your Council, composed of a representative from each of the twelve councilor districts has been very active during the past fiscal year. Each councilor has looked after the interests of the county societies and the members in his individual councilor district. Annual reports of the councilors were read at the Pre-Convention meeting held in January and were published in the February Journal. At this time I will not, therefore, repeat what is contained in their excellent annual reports.

Your Council has held during the past year six annual medical district meetings. This responsibility assigned to the Council has proved to be very constructive and helpful to the membership at large. It gives each member an opportunity to see and hear the officers of the State Association at least once during the year with a minimum amount of travel. It is also a definite saving of the time of the President of your Association and of other officers. It affords a splendid opportunity for the members in each district to assemble together once each year and become better acquainted as well as enjoy good fellowship with their colleagues. It brings the members closer together and affords an opportunity for discussion of Association problems in a much more informal manner than at a meeting with a large attendance, such as the State Association convention.

The total attendance at the six annual medical district meetings this year was 562. Of this number, 387 were members and 175 were visitors and ladies. At the scientific sessions of the district meetings, 24 scientific papers were read and discussed. Your Council feels that this is a very constructive part of the district meetings. It encourages our members to write and present scientific papers and have them published in the Journal. There are more of our members on the scientific programs of the medical district meetings than appear on the scientific program at the annual convention of the State Association. The annual district meetings not only afford this splendid opportunity for our members to present scientific papers, but also afford an opportunity for the members to become better acquainted. Your Council feels that these medical district meetings are a real contribution to the Association's work of the year and have an important

part in creating the spirit of harmony throughout the entire state.

The Council has been urging all county societies to become incorporated. The help of the district councilor has been offered to assist in this if his help should be desired. We have met with some degree of success although not as much as we had hoped for. We recommend that the incoming Council continue this activity until all societies are incorporated.

The Council recommends the addition of two sections to the By-Laws, which I will read at this time and urge that favorable action be taken at tomorrow's meeting of this body:

That Chapter XI be amended to include Sections 14 and 15 as follows: (*See preceding action for text*).

There are a number of counties where there are not enough doctors to organize a separate county medical society. If Section 14 is included in the By-Laws, it will put under the supervision of a regularly constituted county medical society nearby counties until such time as there are sufficient doctors to organize county medical societies of their own. (*See preceding action for text*).

The purpose of the addition of section 15 to the By-Laws as recommended by the Council is to make a definite ruling as to the number of members required for a county medical society to hold its charter. Your Council feels that when the membership of a county medical society falls below a total of three, its charter should be automatically cancelled, provided of course that the councilor in such district has exhausted every effort to assist that county medical society to bring its membership up to this requirement.

The Council would be most ungrateful if it did not recognize with deep appreciation the help given us by Dr. Stewart Thompson. He has not only cooperated with us in our efforts but he has been most valuable to us in collecting and furnishing us with detailed information, making it possible for the Council to have a fairly comprehensive understanding of the State Association and the Council's duties.

Respectfully submitted,  
Herman Watson, *Chairman*.

Doctor Day: You have put up to the Legislative Committee several things to be accomplished. I would like to suggest that your legislative program be left up to the discretion of the Legislative Committee. Even though certain desired legislation is not passed, if we prevent unfavorable and harmful bills from becoming laws, something has been accomplished. It would seem to me that it should not be mandatory for the Committee on Legislation and Public Policy to carry out all of these things.

Dr. J. S. Stewart moved that all matters of legislation be left to the discretion of the Committee on Legislation and Public Policy and the Executive Committee. Seconded by Doctor Bates. Motion prevailed.

Doctor Flipse moved that the House of Delegates empower the Executive Committee to expend the amount of \$10,000.00 over and above the regular budget expenses for the work of the regular committees if necessary and to divide it among the committees as it appears necessary for the performance of their special work.

Doctor Day: I would suggest that no amount be specified. The committees are all economical. The doctors all over the state cooperate, giving their time to the work and paying their own expenses.

Motion seconded, voted and lost.

Dr. J. S. Stewart moved that this body request the Executive Committee to study the question of committee reports being read at the first meeting of the House of Delegates and arrive at the best possible solution of eliminating the reading of these long reports at the first meeting of the House of Delegates. Motion seconded and carried. So ordered.

On motion duly made, seconded and carried, the meeting of the House of Delegates adjourned.

#### FOURTH SCIENTIFIC ASSEMBLY

The Fourth Scientific Assembly was held Wednesday, May 1, at 9:00 a. m., Dr. Walter C. Jones presiding.

The following papers were read and discussed:

13. "Experimental Atabrine Therapy in Granuloma Inguinale" (lantern slides), Alan Brown, Jacksonville.

14. "Medicine, Public Health and Local Government", A. B. McCreary, Jacksonville.

15. "Compensation in Industrial Ophthalmology", Nelson M. Black, Miami.

16. "The Role of X-Ray Therapy in Non-Malignant Disease", Alfred G. Levin, Miami.

17. Clinicopathologic Conference, Franz Stewart, Director, Miami; Philipp Rezek, Pathologist, Jackson Memorial Hospital, Miami.

#### SECOND GENERAL SESSION

The General Session of the Florida Medical Association reconvened at 12 o'clock noon, Wednesday, May 1, 1940 in the Palm Room of the Tampa Terrace Hotel, President Robinson in the chair.

The meeting was called to order.

The guest speaker, Dr. B. R. Kirklin, Head of the Section on Roentgenology, Mayo Clinic, Rochester, was introduced by Doctor Robinson.

Address, "Bleeding Lesions of the Gastro-intestinal Tract," by Dr. B. R. Kirklin.\*

Dr. H. A. Walker was recognized by the chair.

Doctor Walker: I wish to offer a resolution of thanks to all concerned in making this, the Sixty-Seventh Annual Convention of the Florida Medical Association, the success which it definitely has been:

\*To be published in July, 1940, Journal.



### RESOLUTION

BE IT RESOLVED that we, the members of the Florida Medical Association, extend our extreme gratification and appreciation to our host society, the Hillsborough County Medical Society.

Specifically we wish to call attention to the efforts that have been expended by the president of the Hillsborough County Medical Society and general chairman of the convention arrangements, Dr. John R. Boling. In addition, we wish to thank his able cabinet members and committees.

We also wish to express thanks for the splendid cooperation of the Tampa Terrace Hotel, its manager, Mr. George Mason, and its convention director, Mr. Frank Winchell; to the Tampa newspapers which have been unusual in their cooperation and comments in their columns on the doctors of Florida; to the Chamber of Commerce which has cooperated so splendidly and so graciously permitted the use of its building for the House of Delegates and in addition, furnished two young ladies for the information desk, which was a great help.

Doctor Walker moved the adoption of the resolution and that the secretary of the Association be requested to mail letters to all concerned who helped to make this a successful convention. Seconded by Doctor Holden and unanimously carried.

The chair stated that nominations for president-elect were in order. Dr. Walter C. Jones of Miami was nominated by Dr. Edward Jelks. Doctor Holden moved that the nominations close and that the secretary cast a unanimous vote for Doctor Jones. Seconded by Doctors Walker, Feaster and Bryans. Motion prevailed. The chair requested Doctors Holden and Jelks to escort Doctor Jones to the rostrum.

Doctor Jones: Mr. President and fellow members of the Florida Medical Association: You have conferred upon me the greatest honor within your power. I hope to be able in a small way to live up to the responsibility which you have placed upon me. I assure you that there shall not be a lack of effort or failure to consult with the different members of our Association in striving to accomplish during my term of office what is desired and what is best for the medical profession in the state of Florida.

Nominations for first vice-president were called for. Dr. John R. Boling of Tampa was nominated by Doctor Osincup. Doctor Bryans moved that nominations close and that the secretary cast a unanimous ballot for Doctor Boling. Motion prevailed.

Nominations for the office of second vice-president were called for. Dr. Ferdinand Richards of Jacksonville was nominated by Doctor Pound who moved that nominations

close and that the secretary cast a unanimous ballot for Doctor Richards. Motion prevailed.

Nominations for the office of third vice-president were called for. Dr. E. B. Hardee of Vero Beach was nominated by Doctor Waas who moved that nominations close and the secretary cast a unanimous ballot for Doctor Hardee. Motion prevailed.

Nominations for the offices of secretary, treasurer and editor of the Journal were called for. Dr. Shaler Richardson of Jacksonville was nominated by Doctor Rowlett who moved that nominations close and that a unanimous ballot be cast for Doctor Richardson. Motion prevailed.

The chair requested Doctor Bryans and Doctor Gilmer to escort Dr. J. Sam Turberville to the rostrum.

Doctor Robinson: In turning this gavel over to you, Doctor Turberville, I know that you will administer the details of the office as president of the Florida Medical Association with courage, enthusiasm and determination.

Doctor Turberville: It is with extreme pleasure I accept the honor that has been conferred upon me. There are many things to be accomplished during the coming year. It is not expected that we will do anything spectacular. I ask the cooperation of every member of this Association. With that we can succeed. Without it, we fail.

The chair recognized Dr. J. H. Pierpont, chairman of the Advisory Board of Past Presidents, who presented to the outgoing president, Dr. Leigh F. Robinson, the emblem button worn by past presidents.

Doctor Pierpont: I want to ask your indulgence for just a few moments to explain something about the origin of the past president's button. It may not be generally known how it originated. It was Dr. Ralph Greene's suggestion. The Association by official action appointed a committee of two, composed of Dr. Raymond C. Turck and myself, to select a design for this button. After mature consideration the button I hold in my hand was accepted as official, since it contains the colors of the tree which has made Florida famous—the orange tree. The circle of white typifies the beautiful and fragrant white blossoms; the green cross typifies the rich green of the leaves; and the gold which holds the elements together represents the mature orange. It gives me great and unusual pleasure, Doctor Robinson, to place this past president's button in your coat lapel in behalf of the Florida Medical Association and I hope God will give you many years to wear it.

There being no further business, the president sounded the gavel and declared the Sixty-Seventh Annual Meeting of the Florida Medical Association adjourned sine die.

## REGISTRATION

The total registration during the Sixty-Seventh Annual Meeting of the Florida Medical Association, held in Tampa, April 29, 30 and May 1, was 879; members, 522; visiting doctors, 52; exhibitors, 78; Woman's Auxiliary, 227.

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J. SAM TURBERVILLE, OUR PRESIDENT

A true son of the South is Dr. J. Sam Turberville, who was inducted into the presidency of the Association at the recent convention in Tampa. Born in Claiborn, Alabama, May 19, 1875, the son of Joseph S. and Matilda Ikner Turberville, he attended neighborhood schools and later high schools in Perdue Hill and Furman, Alabama. At the age of 22 he entered the University of Alabama from which he received a B. S. degree in 1899, a Ph. G. degree in 1900, and his M. D. degree in 1902.

Following his graduation, Doctor Turberville entered the private practice of medicine in Alabama, where he remained for four years—one at Peterman and three at Snow Hill. He then moved to Century, Florida, where he has practiced for the past 36 years. Doctor Turberville and his wife, the former Julia Ptomy, have seven children, two of whom are Drs. J. K. and J. I. Turberville, who practice with their father in Century.

Doctor Turberville is a Fellow of the American Medical Association, Life Member of the American College of Surgeons, member of the Escambia County Medical Society, Southern Medical Association, Southeastern Surgical Congress, Chattahoochee Valley Medical Association, Gulf Coast Clinical Society, and an associate member of the Florida Radiological Society. He has contributed many articles of worth to the medical literature.



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## ANNUAL CONVENTION HELD IN TAMPA

The Sixty-Seventh Annual Meeting of the Florida Medical Association, held in Tampa, was an occasion which will be long remembered as an outstanding event in the Association's history. The total registration was 879 of which number 522 were members of the Association, 52 visiting doctors, 227 members and guests of the Woman's Auxiliary, and 78 representatives of exhibiting firms.

The Hillsborough County Medical Society, through its officers and well organized committees, apparently overlooked nothing in planning for the comfort and pleasure of its guests. Dr. John R. Boling, president of the Society and general chairman of the local committees on arrangements, may well be proud of the organization he represents.

### HOUSE OF DELEGATES

The first session of the House of Delegates convened Monday at 1:30 p.m. in the Chamber of Commerce Building, with 71 delegates seated. Dr. Edward Jelks of Jacksonville was elected delegate to the A. M. A. for the two-year term from January 1, 1941 to December 31, 1942 and Dr. Herbert L. Bryans of Pensacola was elected his alternate. On recommen-

dation of the Executive Committee, Jacksonville was selected as the place for the 1941 annual meeting.

Three reference committees of five members each were appointed from the delegates present. Each report, resolution, etc. read at this session of the House was referred to one of these committees for consideration before final disposition at the second session of the House. Members interested in a particular report or resolution were privileged to attend the reference committee meeting where long discussions were permitted. This not only gave the subject under consideration a more thorough analysis but eliminated a great deal of discussion from the floor of the House of Delegates and, when the questions came up for action at the second session, those present had the benefit of carefully worked out recommendations from a reference committee. The plan was so successful that the by-laws were amended to provide for three reference committees composed of five delegates each—one a committee on Health and Education, one on Public Policy, and one on Finance and Administration.

On recommendation of the Council, the by-laws were amended to place the minimum membership of a county medical society at three. If the membership of a county medical society falls below this minimum, its charter is automatically revoked. The by-laws were also changed, on recommendation of the Council, to assign each unorganized county to a county medical society until such time as that county shall have sufficient doctors to organize separately. There were a number of other amendments to the by-laws that will make the working of the organization more efficient.

A charter was issued in the name of the Madison-Suwannee County Medical Society, the application having been signed by nine doctors from these two counties.

The complete text of all amendments to the by-laws, reports of committees, resolutions, and actions taken by the House of Delegates may be found in the preceding pages of this Journal.

### GENERAL SESSIONS

Two general sessions were held during the convention, the first on Monday at 4:30 p.m. in the Palm Room. The president's annual address was delivered by Dr. Leigh F. Robin-

son and the annual report of the secretary-treasurer-editor and managing director was read by Dr. Shaler Richardson. Reports were received from our delegates to the Medical Association of Georgia and the delegates from the Association of Georgia were recognized.

The second general session convened Wednesday at 12 o'clock in the Palm Room. By invitation an address on "Bleeding Lesions of the Gastro-Intestinal Tract" was delivered by Dr. B. R. Kirklin, head of the Section of Roentgenology, Mayo Clinic, Rochester, Minnesota.

Dr. Walter C. Jones, Jr. of Miami was elected president-elect; Dr. John R. Boling of Tampa, first vice-president; Dr. Ferdinand Richards of Jacksonville, second vice-president; Dr. E. B. Hardee of Vero Beach, third vice-president; and Dr. Shaler Richardson of Jacksonville was re-elected secretary-treasurer and editor of the Journal. Complete information concerning the two general sessions may be found in the preceding pages of this Journal.

#### SCIENTIFIC ASSEMBLIES

The first scientific Assembly was held Monday at 7 p.m. and included three papers; the second on Tuesday at 9 a.m. with three papers and a symposium on heart disease; the third on Tuesday at 1:30 p.m. at which time five papers were presented. Five papers were read at the fourth scientific assembly which was held Wednesday at 9 a.m. The House of Delegates highly commended the Association's Committee on Scientific Work for the well selected and arranged program which comprised the scientific assemblies. Names of the essayists and titles of their papers were published in the April Journal and the complete papers with discussions will appear in coming issues.

#### SPECIALTY SOCIETIES

During Sunday and up until Monday noon eight specialty groups held annual meetings at which time excellent scientific programs were presented. These specialty meetings are an important part of the annual conventions. One of the delegates from the Medical Association of Georgia made this statement: "I think that in time we will all come to do just what you are

doing—that is, form groups of specialties. You are ahead of us in that respect."

Complete programs for the specialty societies were published in the April Journal and in the following pages of this issue may be found a review of the various meetings.

#### ENTERTAINMENT

The smoker, held Monday at 9 p.m. at the Palma Ceia Golf Club, was first scheduled as "stag" but later changed to include the ladies. It was a delightful occasion, thoroughly enjoyed by all who attended.

Following a cocktail hour, the Association dinner was held on Tuesday evening in the air-conditioned Palm Room of the Tampa Terrace Hotel, with Dr. J. C. Vinson in the role of master of ceremonies. Attractive prizes, which had been on display in the hotel lobby, were awarded to the winners of contests in golf, skeet and fishing. Dr. J. C. Dickinson paid tribute to the many donors of the valuable prizes and to the members of his committee who were responsible with him for the well worked out golf schedule.

Dr. D. R. Murphey, Jr. and Dr. Robert G. Nelson, with their committeemen, were largely responsible for arranging the evening's entertainment which consisted of local talent and professional acts which delighted the audience. A fine orchestra furnished music during the dinner and for the dance which followed. Mr. George Mason, Mr. Frank Winchell and their associates made available to the guests all of the many facilities of the headquarters hotel.

Special entertainment was provided for the ladies by Mrs. W. M. Rowlett and her co-workers. More complete details concerning the program of entertainment is given in the following pages of this Journal under the caption "Convention Echoes".

#### EXHIBITS

Three instructive scientific exhibits were on display throughout the meeting, as scheduled in the June Journal. Thirty-three technical exhibits, supervised by 78 representatives of exhibiting firms, were well attended and contributed materially to the success of the convention.



## SPECIALTY SOCIETIES

### FLORIDA RAILWAY SURGEONS' ASSOCIATION

This was undoubtedly the most successful and best attended meeting of the Railway Surgeons' Association in the past six years. The president and Executive Committee revived the old custom of staging an annual smoker this year, which was such an attractive item of former years. The smoker was held at Rubin's Spanish Restaurant on Sunday night and at this dinner 34 officers and members of the Railway Surgeons assembled, with several guests of President Clark. The guest speaker on this occasion was Dr. Roy J. Holmes of Miami, who always keeps his audience interested. Doctor Holmes' address was on "The Experiences of a Chief Surgeon" which was especially interesting and appropriate, as the material was taken largely from the records and experiences of his father, Dr. Walter B. Holmes of Wadley, Georgia, chief surgeon of several railroads which operate in that territory.

The scientific program directed by Dr. John W. Alsobrook, chairman of the Scientific Committee, was both instructive and pertinent to the work of railway surgeons, as it stressed traumatic and emergency surgery. There was a general feeling of appreciation among officers and members of the Railway Surgeons for the consideration shown through important changes in the schedule of time allotted for separate meetings of specialty societies. With Sunday open for the annual smoker or dinner and Monday forenoon for the scientific session and business meeting, the annual gathering next year will undoubtedly surpass the record made this year.

The following officers were elected: president, Dr. Leland F. Carlton, Tampa; president-elect, Dr. J. W. Alsobrook, Plant City; vice-president, Dr. Z. Brantley, Grandin; secretary-treasurer, Dr. Walter C. Page, Cocoa. The total attendance at this meeting was 69.

\* \* \*

### FLORIDA PEDIATRIC SOCIETY

This society's activities were introduced by a dinner meeting on Sunday at 8 p. m. Following the dinner a scientific paper was read by a guest speaker. The Society reconvened on Monday at 10 a. m. at which time a scientific program was enjoyed. The present officers of

this society will carry through until the fall meeting at which time new officers will be elected. There were 30 in attendance at this meeting.

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### FLORIDA CHAPTER OF THE AMERICAN COLLEGE OF PHYSICIANS

The Florida Chapter of the American College of Physicians convened at 10 a. m. on Monday. Various subjects relating to the welfare of organized medicine were discussed, in addition to the regular program. Eight guests from Havana, Cuba, representing the leading practitioners of that city, were present, most of whom will probably begin organizing a chapter of the College of Physicians in Havana. Dr. C. H. Cocke, regional governor, was present and also Mr. E. R. Loveland, secretary of the College. Dr. Louie Limbaugh of Jacksonville was elected president and Dr. Kenneth Phillips of Miami, re-elected secretary.

In the April Journal and the printed program this session was listed under the caption, "Florida Internists' Society." By action taken during the meeting, the name was officially changed to the Florida Chapter of the American College of Physicians. The attendance at the meeting was 62.

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### FLORIDA SOCIETY OF DERMATOLOGY AND SYPHILOLOGY

The regular quarterly meeting of this Society was held at 9 a. m., Monday, in room 715, Citizens Bank Building. Dr. C. A. Andrews conducted an interesting skin clinic, with a business meeting and luncheon following. It was decided to hold a symposium on Syphilis at the next meeting in Orlando in August, 1940, the program to be in charge of Drs. Wiley Sams, Chadbourne Andrews and Lauren Sompayrac. Guests at the meeting were Drs. B. R. Tinkler, Lake Wales; Waldo Horton, Winter Haven and J. A. Mease, Dunedin. Officers are not elected until at a later meeting. The total attendance at this meeting was 15.

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### FLORIDA SOCIETY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

This society met on Monday at 11 a. m. at the Hillsboro Hotel. Four very interesting papers were presented as scheduled in the program published in the April Journal. At the luncheon which followed the scientific ses-

sion, officers were elected: president, Dr. H. Marshall Taylor, Jacksonville; vice-president, Dr. S. B. Forbes, Tampa; secretary-treasurer, Dr. Carl E. Dunaway, Miami. The attendance at this meeting was 63.

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#### FLORIDA ASSOCIATION OF INDUSTRIAL SURGEONS

This meeting convened on Monday at 11 a. m. with four scientific papers followed by a round table discussion. On Tuesday at 12:30 p. m. a luncheon meeting was held. The newly elected officers of this Association are: president, Dr. A. M. Bidwell, Tampa; president-elect, Dr. G. F. Oetjen, Jacksonville; vice-president, Dr. Kenneth A. Morris, Jacksonville; and secretary-treasurer, Dr. T. H. Roberts, Lakeland. There was an attendance at this meeting of 36.

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#### HEALTH OFFICERS' SECTION OF THE FLORIDA PUBLIC HEALTH ASSOCIATION

The Health Officers' Section met on Monday at 9 a. m. Four papers were presented as scheduled in the program published in the April Journal. The meeting was most interesting and the discussions well presented. Officers of this group are elected at its December meeting. The total attendance was 30.

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#### FLORIDA RADIOLOGICAL SOCIETY

The first session was held Sunday at 10 a. m., with luncheon at 12:30 p. m. and the scientific program following. Another session was held at 7 p. m. and on Monday at 9 a. m., the Society reconvened, spending the entire forenoon in a scientific session.

The Society was extremely fortunate in having as its guest speaker Dr. B. R. Kirklin of the Mayo Foundation, one of the world's outstanding radiologists. His illustrated talk on "Postoperative Gastric Conditions" was heard with great interest by all present. It excited considerable discussion among the members and numerous visitors who had come to Tampa a day before the Florida Medical Association meeting in order to hear Doctor Kirklin's address.

The meeting was marked by the usual round table discussions on interesting films and the radiological problems encountered by its mem-

bers. At the business meeting following the opening session, the Florida State Board of Health was assured the cooperation of the Society in its efforts further to control tuberculosis in the public schools.

Newly elected officers are: president, Dr. Joseph H. Lucinian, Miami; vice-president, Dr. John N. Moore, Ocala; secretary-treasurer, Dr. Elliott M. Hendricks, Ft. Lauderdale. There was a total attendance of 45.

### CONVENTION ECHOES

#### BOARD OF PAST PRESIDENTS

W. HENRY SPIERS, *Secretary*

The General Advisory Board of Past Presidents met at breakfast Tuesday morning at 7:30. It was decided to recommend to the House of Delegates that a committee of historians be created. The question of issuing a certificate to each past president was discussed and approved. Dr. Frederick J. Walter of San Diego, California, our Association's president in 1918, was present, this being his first trip to Florida since 1923. All of the living past presidents of the Association were registered at this annual convention with the exception of Dr. Robert H. McGinnis of Jacksonville and Dr. F. Clifton Moor of Tallahassee. Dr. Ralph Greene of Coral Gables was elected chairman and Dr. W. Henry Spiers of Orlando, secretary.

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#### CABINET

JOHN R. BOLING, *Chairman*

It is astonishing at times with what ease seemingly difficult problems can be solved by united effort. This was so in our preparation for the State Convention in Tampa. The things accomplished were not due to the efforts of any single committee or small group but to the whole-hearted backing and effort of every member of the local Society. We are indebted to many other than our local members, Stewart Thompson, of course, being the one who, with his vast experience, guided us so well.

We hope that our efforts were well received and we feel from the kind expressions of the members at large that they were. But regardless of all else, we here in Tampa, have been well repaid. The opportunity of working together on something in which every man in the Society was interested has drawn us closer together and made us more appreciative of the other fellow and his efforts. There is no doubt but that there is a finer feeling among our members, every man sensing the satisfaction that follows work well done.

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#### FINANCE

The chairman of this committee, Dr. Robert G. Nelson, was too modest to contribute a writeup for this section of the Journal. The Finance Committee is a part and parcel of every local committee on entertainment, as the question of securing and budgeting money comes under its jurisdiction. Doctor Nelson and his committee not only handled all financial questions, but made many real contributions aside from their own responsibilities in connection with activities of the other committees on entertainment. Doctor Nelson reported that there were ample funds to pay all bills incurred by the Hillsborough County Medical Society in connection with the entertainment of the convention.



### SMOKER

WILLIAM P. ADAMSON, *Chairman*

If old man Attendance-Record didn't take a belting then certainly his fellow-traveler, Precedent, was put through the ropes at the Smoker held Monday night at the Palma Ceia Golf Club.

Beginning at 7:30 o'clock, guests arrived at the club and after an optional visit to the bar, repaired to the ballroom where dinner was served in buffet style, the while Frank Grasso and his orchestra played continuously until after 9 o'clock.

Meanwhile, the women, who were attending a cocktail party and dinner of their own at the Tampa Yacht and Country Club, tired of their manless state and, just as soon as the law-of-the-host-entertainment-committee allowed, accepted the invitation which only that day had been officially extended to them to crash the party.

Swelled by the arrival of other latecomers, the crowd assembled on the terrazzo dance floor, which had been converted into an outdoor theatre, to watch the variety show which took place in front of the bandstand with orchestral accompaniment from Grasso and his merry men.

Sid White of Miami arranged the program and acted as master of ceremonies to introduce the artists who included a seemingly endless procession of Broadway notables wintering in Florida.

In spite of the chilling breeze of an unseasonable Florida April night, so well-received were the performers who ran the gamut of entertainment from classical vocal offerings to riotous comedy dance and juggling acts, fitting their patter appropriately to the assembly, that they held the audience which sat, stood or leaned on the chairs provided on the floor, the walks surrounding it, and the broad stairs and veranda of the clubhouse overlooking the scene, until well onto midnight.

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### TRANSPORTATION

JOHN C. VINSON, *Chairman*

The members of the Transportation Committee found the visiting doctors so cooperative that we all obtained a lot of fun from our own activities. Even the boys who drove the free busses to and from the Palma Ceia Club were loud in their praise of the passengers.

One of the bus drivers expressed verbally the sentiment of the Hillsborough Medical Society when he said: "Them Docs was swell guys."

Mrs. Shaver who was in charge of the motorcade for the visiting wives of the doctors brought together at the end of their trip the finest group of women the Tampa Yacht Club has seen in a long time.

I think every doctor in Tampa felt rather lonely following the day of the Convention's end. Every doctor in this County enjoyed the privilege of presenting to this community the fine group of men and women who represented so wonderfully the aims and ideals of organized medicine.

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### LADIES' ADVISORY

WILLIAM M. ROWLETT, *Chairman*

As chairman of the Advisory Committee to the Women's Division of the Florida Medical Association, my pleasure is indeed great in writing a sketch of what was acknowledged as one of the largest and most successful conventions ever held in the history of our State Medical Conventions. In titling this "echoes" do not think for a moment these echoes have ceased. They are still resounding with reverberations.

It was a privilege beyond expression to be associated with such a splendidly organized and charming group as the Women's Division. Their entertainment, so lavishly planned, was carried out with military precision, no confusion, not a hitch in schedule, each fete ending with great éclat. Taking advantage of the geographical location and cosmopolitan attractions, the set-up for entertainment was

unique. After a motorcade to the Gulf beaches, traversing both the Davis Causeway and famous Gandy Bridge, an elaborate cocktail party and dinner awaited the ladies upon their return to the Tampa Yacht and Country Club. The ladies were then asked to join the doctors at the Palma Ceia Golf Club, where their annual smoker was held, to witness a floor show of unusual versatility. There was much conviviality and renewal of old friendships and acquaintances among the doctors of the State.

A Spanish luncheon at one of our popular restaurants in Ybor City, where the Latin population adds much foreign color and atmosphere to any occasion, had as guest speaker, Mrs. Rollo Packard of Chicago, National President of the Medical Auxiliary. She was introduced by Mrs. Lawrence Ingram of Orlando, President of the Auxiliary to the Florida Medical Association. This luncheon followed the business meeting and election of new officers of the Auxiliary. The annual banquet held in the Palm Room of the Tampa Terrace Hotel, preceded by a cocktail party, will long be remembered. Under canopied skies, in the glorious, salubrious air of Florida, the cocktail party was held in a typical tropical setting. Our Southern women, famous for their beauty, graciousness and delicacy of charm, never looked lovelier. The Palm Room was crowded to capacity, where a delicious dinner was served, interspersed with speeches, and original, clever and professional entertainment.

With the passing of this 1940 State Medical Convention I sincerely believe that the doctors all over the State will regard future conventions as a loop-hole of escape from the routine of daily practice with its accompanying anxieties and responsibilities, where they can relax in the atmosphere of gaiety and good companionship, attend the lectures, scientific exhibits and reading of papers, and return to their respective homes refreshed and with renewed vigor.

From now on, when the Convention calls, let's mobilize and march forward.

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### DINNER

DAVID R. MURPHEY, JR., *Chairman*

On Tuesday evening, April 30, following a cocktail party on the balcony of the Palm Room of the Tampa Terrace Hotel, 447 members, wives and guests of the Florida Medical Association assembled in the Palm Room for the annual Association Dinner. During the seating of the guests music was furnished by Max Platner and his orchestra.

Dr. J. C. Vinson, our able toastmaster presented the Right Rev. John B. Walthour who said grace. During the dinner a pantomime was presented.

Margaret Hanger, the famous birth control advocate, was unable to give her inspiring address due to innumerable interruptions. During her talk she was interrupted by a group of picketing obstetricians in caps, masks, operating gowns and gloves. Their placards were as follows: (1) "Birth Control is Unfair to Organized Labor," (2) "The More Kids the More Kale," (3) "Keep the Kiddies Coming," (4) "Papa Dionne had the Right Idea," (5) "Don't Take Away our Delivery Service," (6) "The More Diapers the More Dough," (7) "We want Gobs of Obs.," (8) "Babies are our Bread and Butter," (9) "Propagation Pays the Rent," (10) "Our Theme Song, 'I Can't Give You Anything But Love, Baby.'" Margaret went on with her message but Hitler and four of his Brown shirts demanded recognition. Hitler made an inspiring talk in his native tongue while his body guard held on high the following placards: (1) "He put the 'Pop' in Population," (2) "To Hell with Propaganda Give Him Propagation!" (3) "Nazi to Birth Control," (4) "Hanger'd make us Unproductive. Our program is more constructive." Not to be outdone by his imitator Mussolini entered with four of his black shirts and made an equally inspiring speech in Italian. His cohorts displayed the following mottos: (1) "Banish the Bachelors, Speed up the Spinsters," (2) "Marry in Haste and Repeat at Leisure," (3) "Fascisti—Don't Take No for

an Answer," (4) "Bachelor's Brats make Good Brass Hats." Mussolini departed amid the blare of trumpets and was replaced by a poorly dressed woman with a string of pitiful little children. Margaret was immediately touched by the woman's misfortunes. She told Margaret that a case of the flu by her husband had kept her from winning the Canadian derby. Margaret presented the lady with a package with directions inside. The poor misguided soul then held on high a banner: "Saved at Last."

The toastmaster then announced that promptly at 9 p. m. a broadcast had been arranged especially for the evening from Washington and in the interval presented the outstanding personalities at the dinner none of whom were allowed to speak.

Promptly at 9 p. m. over the loud speakers, W. D. A. E. presented Thurman Barnold who introduced Senator Tagner. The Senator spoke briefly on what he had in store for the profession when he got them under control. After his speech interns dressed in hospital attire marched around the room holding the following placards on high: (1) "Do you want a Public Works Appendectomy?" (2) "Would we Come Under the Secretary of the Interior?" (3) "Francis Perkins is Secretary of Labor—But we Deliver the Goods," (4) "We Hope that we shall Never see a Senator do a D&C." (5) "Legislators Pass the Bills—Let us Doctors Pass the Pills," (6) "Will you let Some Government Sap Tell you when to do a Lap?" (7) "A Rail Splitter in the White House is one Thing—A Fee Splitter another," (8) "Who wants to Fill out a Form when Their Form Fills Out."

While the facilities of W. D. A. E. were still available a special message from Dr. John R. Prinkley was received from Del Rio. Dr. Prinkley spoke on rejuvenation with goat glands and introduced a Florida physician on whom he had performed one of his miracles. The physician's speech was difficult to understand due to the bleating pitch to his voice.

The March of Time With Reference to Medicine was then presented: 1890 Dr. Horsan Buggy (top hat, Prince Albert coat, buggy whip and hot water bottle); 1920 Dr. Plushbottom, dressed in morning coat and wearing a Van Dyke beard, attended by 2 chauffeurs, and 4 nurses; 1940 Dr. Braken Even, unattended, dressed in plain business suit; 1945 Dr. Downan Out, dressed in rags, carrying placard, "I supported the New Deal".

Reverend Walthour then told the audience how touched he was over the sacrifice that the poor woman had made to try to make ends meet; that she was a deserving woman whom he knew personally. This so touched one of the lady guests that she offered to sell her clothes. These were auctioned off until she demanded a screen for protection from the eyes of the curious after sale of her dress. A screen was found and the auction proceeded each under garment being sold. When the lady was apparently stripped the screen brought a fancy price. Behind the screen, instead of a nude woman, was a little negro boy who entertained the gathering with a tap dance.

A dance and a professional floor show followed the dinner.

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#### ALUMNI AND FRATERNAL LUNCHEONS

BLACKBURN W. LOWRY, *Chairman*

The Emory University Medical Alumni Association held a delightful luncheon at the Hillsboro Hotel, April 30. The luncheon was attended by over 65 doctors. Dr. Herbert White of St. Augustine was elected president for the ensuing year and Dr. W. Wardlaw Jones, secretary.

The Phi Beta Pi Fraternal Alumni Luncheon was held at the Columbia Restaurant Tuesday noon. Dr. H. A. Barge, of Miami, and Dr. John S. McEwan, of Orlando, were elected president and secretary, respectively, for the coming year.

The Phi Chi Fraternal Alumni group lunched together at the Tampa Terrace Hotel, and it was decided to make

the luncheon an annual affair. Dr. Gordon H. Ira, of Jacksonville, was appointed as a committee of one to make the necessary arrangements for the luncheon to be held in Jacksonville next year.

Doubtless there are a number of other medical school and fraternal groups who would like to lunch together during the convention period. It would greatly assist the host society if information could be furnished the chairman of the Fraternal and Alumni Committee a few days before the Convention convenes.

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#### SKEET

JOSEPH W. TAYLOR, *Chairman*

The Skeet Tournament which was held at the Tampa convention was adjudged by all who entered to be a definite success. This feature of the State Convention, which was inaugurated at Daytona Beach in 1939, drew even a larger field this year. It was felt that this tournament was a valuable addition to the Convention program as it provided an opportunity for those who did not play golf to compete in some contest. Twelve desirable prizes were donated by the local merchants and representatives of drug and surgical companies, whose wholehearted cooperation made this tournament possible. Prizes were won by the following doctors, on the score of the best 50 rounds:

*First Flight:* 1st, W. C. Bayless, Jacksonville; 2nd, C. C. Grace, St. Augustine; 3rd, J. L. Summerlin, Gainesville; 4th, Wilmot Brown, Tallahassee.

*Second Flight:* 1st, Herbert White, St. Augustine; 2nd, Rollin Jefferson, Tampa; 3rd, J. E. Maines, Gainesville; 4th, J. W. Taylor, Tampa.

*Third Flight:* 1st, W. P. Duncan, Tampa; 2nd, L. L. Dozier, Tallahassee; 3rd, R. R. Duke, Tampa; 4th, R. T. Heath, Tampa.

There were six other doctors who shot only one round and therefore were not eligible to compete for prizes. Eighteen in all took part in the tournament and with the interest shown it should be much larger next year.

The prizes were donated so graciously that it was a pleasure to serve on the committee.

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#### GOLF

J. C. DICKINSON, *Chairman*

The annual golf tournament of the Florida Medical Association was held at the Palma Ceia Golf Club, April 28, 29, and 30. Eighty-two golfers participated in the tournament. The Orlando trophy was won by Dr. L. B. Dickerson, Clearwater.

The tournament was arranged in three flights according to the handicaps submitted by the contestants. Prizes were awarded as follows:

*First Flight (Net):* 1st, Frank S. Adamo, Tampa; 2nd, J. L. Summerlin, Gainesville; 3rd, James T. Cowart, Tampa; 4th, J. M. Dell, Gainesville; 5th, H. J. Stipe, Ft. Myers; 6th, J. G. Gilchrist, Bartow; 7th, Jack Peavy, Ft. Lauderdale; 8th, F. D. Gray, Orlando.

*First Flight (Gross):* 1st, W. F. Davey, Stuart; 2nd, C. A. Rudisill, Tampa; 3rd, R. M. Harris, Miami; 4th, J. R. Chandler, Daytona Beach; 5th, C. E. Dunaway, Miami; 6th, R. P. Henderson, Orlando; 7th, R. G. Nelson, Tampa; 8th, W. H. McCullagh, Jacksonville.

*Blind Bogie:* 1st, Colquitt Pearson, Miami; 2nd, G. L. Cook, Tampa.

*Second Flight (Net):* 1st, L. B. Dickerson, Clearwater; 2nd, H. B. Lott, Tampa; 3rd, Joseph Halton, Sarasota; 4th, H. M. Cook, Tampa; 5th, F. J. Payton, Miami Beach; 6th, B. W. Lowry, Tampa; 7th, Richard Ombres, West Palm Beach; 8th, Shaler Richardson, Jacksonville.

*Second Flight (Gross):* 1st, John R. Boling, Tampa; 2nd, M. A. Nickle, Clearwater; 3rd, John Herring, St. Petersburg; 4th, W. E. Ross, Jacksonville; 5th, John S. Helms, Tampa; 6th, W. C. Thomas, Gainesville; 7th, C. L. Perry, Miami; 8th, J. N. Moore, Ocala.



*Blind Bogie*: 1st, Jack Cleveland, Coral Gables; 2nd, P. B. Welch, Miami.

*Third Flight (Net)*: 1st, Gordon Ira, Jacksonville; 2nd, W. E. Sinclair, Orlando; 3rd, C. H. Kirkpatrick, Arcadia; 4th, Stephen Gylard, Tampa; 5th, E. B. Hardee, Vero Beach; 6th, V. D. Stone, West Palm Beach; 7th, H. A. Knowlton, Tampa; 8th, W. C. Roberts, Panama City.

*Third Flight (Gross)*: 1st, J. W. Taylor, Tampa; 2nd, Homer Pearson, Miami; 3rd, C. O. Anderson, St. Petersburg; 4th, E. M. Hendricks, Ft. Lauderdale; 5th, G. H. McSwain, Arcadia; 6th, W. S. Manning, Jacksonville; 7th, S. F. Smith, Lakeland; 8th, S. W. Fleming, West Palm Beach.

*Blind Bogie*: 1st, T. E. Daly, Palm Beach; 2nd, J. L. Hargrove, Bartow.

*High Score*: 1st, L. M. Gable, St. Petersburg; 2nd, H. O. Brown, Tampa.

The following is a list of individuals and firms who, as an expression of their friendship and interest, donated prizes for the 1940 Annual Golf Tournament:

Adams Prescription Shop, American Optical Co., Bennett's Drug Co., Bize's Bayshore Pharmacy, F. T. Blount Co., Armando P. Boza Funeral Home, A. R. Christy, Columbia Restaurant, Cuesta-Rey & Co., Cutter Laboratories, Deitz Drug Store, DuPont Film Co., Eastman Kodak Co., O. Falk's Dept. Store, Floridan Hotel, Larry Ford, General Electric X-ray Corp., Greenman Co.

Hav-a-Tampa Cigar Co., Curtis Hixon, Steve Hyer, Levy Drugs, Inc., Liggett's Drug Store, Lisbon Drug Store, A. C. Logan, Lord & Fernandez Funeral Home, Maas Bros. Inc., Mass the Habadasher, Madison Drug Co., McKesson-Groover-Stewart Drug Co., McKesson & Robbins, O'Brien Drug Store, Orange Pharmacy, Palma Ceia Drug Store, Parr Drug Co., Peninsular Telephone Co., Pet Milk Co., Plant Park Pharmacy.

Joe L. Reed, B. Marion Reed, E. Regensberg & Sons Inc., Harry Roberts Cigar Co., Joe Regueira, Nolon Scaglione, Sears Roebuck & Co., Seminole Furniture Co., Sharp & Dohme, Inc., Shea & Prange, Southeastern Optical Co., Surgical Supply Co., Tampa Drug Co., Tampa Electric Co., Ralph Thomas, Valencia Gardens, Walgreen Drug Store, Wilson Sammon Co., Wolf Bros. Inc.

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#### HOTELS

JAMES L. ESTES, *Chairman*

Rumors are still going around that the visiting members of the Association acclaim the Tampa meeting one of the finest yet held. The finest thing about it is the happiness that we doctors in Tampa derived from being hosts to such a splendid meeting.

As chairman of the Hotel Committee, I wish to state that we had the finest cooperation from the hotel managers and their attendants. I have not heard a derogatory remark from anyone. My Committee stated to the hotels what was wanted, and they invariably provided that and more. I wish to express my appreciation for this and to the members of my committee who served so efficiently.

### BIRTHS, MARRIAGES AND DEATHS

#### BIRTHS

Dr. and Mrs. Edson J. Andrews of Tallahassee announce the birth of a son, Edson James, Jr., on April 30, 1940.

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Dr. and Mrs. Steve R. Johnston of Ft. Pierce announce the birth of a daughter, Venetia Harwell, on May 10, 1940.

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Dr. and Mrs. Frank G. Slaughter of Jacksonville announce the birth of a son, Frank G., Jr., on May 15, 1940.

Dr. and Mrs. Edgar W. Stephens of West Palm Beach announce the birth of a daughter, Patricia Lee, on March 29, 1940.

#### MARRIAGES

Dr. Francis D. Pierce and Miss Lucy Kyle Grant of Ft. Lauderdale were married June 2, 1940.

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Dr. C. Kirby Smith and Miss Evelyn Elizabeth Osteen of Miami were married May 17, 1940.

#### DEATHS

Dr. Ernest B. Hatch of Miami died April 2, at the age of 53.

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Dr. Frank S. Jennings of St. Petersburg died May 9, 1940.

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Dr. Ralph E. Stevens, Chief Physician at the Florida State Hospital, died suddenly at Sanford on the evening of June 6.

### STATE NEWS ITEMS

The 19th annual scientific and clinical session of the American Congress of Physical Therapy will be held September 2 - 6, 1940 at the Hotel Statler, Cleveland, Ohio.

The mornings will be devoted to the annual instruction course, enabling attendance at both the course and scientific sessions which will be given in the afternoon and evenings. This will minimize the time element and permit attendance at both functions during the same week. The seminar and convention proper will be open to physicians and qualified technicians.

For further information address American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago.

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Dr. J. W. Hayes and family left Jacksonville on May 1 by motor for the Pacific Coast for a month's trip. While away, Doctor Hayes attended the annual meeting of the California Medical Association held at Coronado, May 6 - 9.

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Florida doctors who attended the 24th Annual Session of the American College of Physicians at Cleveland, April 1 - 5 were: Theodore F. Hahn, Deland; Turner Z. Cason, Lucien Y. Dyrenforth, Stanley Erwin, Louis M. Limbaugh, Arthur J. Logie, A. B. McCreary, J. Webster Merritt, Jacksonville; C. F. Roche, Miami Beach; Fred Mathers, Orlando; Norval M. Marr, St. Petersburg; W. C. Blake, George L. Cook, Tampa; and W. Wellington George, West Palm Beach.

Dr. Frederick Oetjen of Jacksonville attended a postgraduate course in Industrial Medicine last month, given by the American College of Physicians at the Henry Ford Hospital, Detroit, Mich. The following week he attended a sectional meeting of the American College of Surgeons in Detroit.

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The Southeastern Section of the American Congress of Physical Therapy held its meeting on May 20 and 21 at the Atlanta-Biltmore Hotel, Atlanta. Dr. Earl C. MacCordy of St. Petersburg was chairman and Dr. Kenneth Phillips of Miami was secretary of the Section. The following members of the Florida Medical Association presented papers: Kenneth Phillips, Miami: "Essentials of Fever Therapy"; A. R. Hollender, Miami Beach: "Physical Therapy in Ear, Nose and Throat Conditions"; John J. Jares, Lakeland: "Therapeutic Effects of Radiation with Various Wave Lengths".

Florida doctors who attended this session were: Cecil Stockard, Bradenton; L. L. Whiddon, Ft. Pierce; J. B. Black, Jacksonville; R. L. Cline, John J. Jares, Lakeland; Kenneth Phillips, A. W. Wood, Miami; A. R. Hollender, Miami Beach; J. J. McGuire, Pensacola; Earl C. MacCordy, St. Petersburg; E. F. Carter, Tampa; R. H. Baldwin, W. E. Bippus, W. Palm Beach.

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Florida doctors who attended the annual meeting of the Medical Association of Georgia in Savannah, April 23-26, were as follows: W. H. Brooks, Frank L. Fort, O. E. Harrell, W. G. Harris, Gerry R. Holden, G. F. Oetjen, G. W. Richardson, W. McL. Shaw, E. W. Veal, and L. M. Wachtel, Jacksonville; P. J. Manson and Homer L. Pearson, Miami; T. H. Davis, Shamrock.

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Dr. J. R. Nieder of Delray Beach left June 10 for a six weeks' intensive course in Medicine given at Harvard University. He will also spend some time in New York and Chicago before his return.

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Dr. Shaler Richardson of Jacksonville attended the meeting of the American Ophthalmological Society at Hot Springs, Va., the early part of June.

Dr. Frederick K. Herpel of West Palm Beach was guest speaker at a meeting of the Palm Beach County Bar Association on the evening of May 27. His subject was "Medical Testimony."

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### ERNEST BRUCE HATCH

Dr. Ernest B. Hatch, who practiced medicine in Miami for 24 years, died April 2, 1940.

Doctor Hatch was born in Worcester, Massachusetts, November 25, 1886. His medical training was received at the Atlanta College of Physicians and Surgeons from which he graduated in 1910. The following year he was licensed to practice in Florida and moved to Miami in 1916 where he built up a large practice in the down-town section of this fast growing city. He was truly a family doctor to hundreds of Miami's middle class families, devoting his full energies to the relief of suffering; respected and admired by patients, friends and associates.

He is survived by his widow, Mrs. Mamie Hatch; two sons, Ernest and James; a daughter, Shirley; and his parents, Mr. and Mrs. James R. Hatch.

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### DAVID ARTHUR MILLS

Dr. David A. Mills of Zephyrhills died suddenly while in his office, on the evening of April 23. He had been in declining health for several years but had improved to the extent that he had been able to resume his practice.

Docor Mills was born in 1878. He attended the University of Michigan Homeopathic Medical School at Ann Arbor from which he received his M. D. degree in 1912. In 1916 he moved to Zephyrhills, Florida, which he made his permanent home and where he built up a large practice. He was a member of the Pasco - Hernando - Citrus County Medical Society, the Florida Medical Association, and a Fellow of the American Medical Association.

The only known surviving relatives are a sister in France and a nephew in Tennessee.

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## COMPONENT COUNTY SOCIETIES

### BAY

The Bay County Medical Society stands 100% paid for 1940. This society is headed by A. H. Lisenby, president; W. E. Middlebrooks, vice-president; and W. C. Roberts, secretary-treasurer. Congratulations!

At a meeting of this society, held at the City Hall, Panama City, on the evening of April 18, Drs. J. M. Hoffman, S. G. Kennedy, M. A. Lischkoff and M. W. Dodson of Pensacola were guests.

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### DADE

A symposium on Coronary Artery Disease comprised the scientific program of the Dade County Medical Society at its meeting held at 8:30 p. m., May 7. Six papers were presented, as follows:

1. "General Aspects of Coronary Artery Disease", C. F. Roche.
2. "Psychological Aspects of Coronary Injury", M. Jay Flipse.
3. "Gastro-Intestinal Manifestations of Coronary Disease", P. B. Welch.
4. "Electrocardiographic Alterations in Coronary Disease", Franz Stewart.
5. "Pathology of Coronary Disease", Philipp Rezek.
6. "Incidence and Prognosis in Coronary Disease", Robert M. Harris.

Following the scientific program, a motion picture film on "Technic of Oxygen Therapy" was shown.

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### DUVAL

Two papers were read before the meeting of the Duval County Medical Society, held on the evening of May 7 in the Library at the State Board of Health Building: "Hemorrhage as a Complication of Pregnancy", by S. R. Norris and "Forceps in Obstetrics", by A. D. Stollenwerck. A business session followed, after which refreshments were served.

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### PASCO-HERNANDO-CITRUS

Dr. R. D. Sistrunk entertained the Pasco-Hernando-Citrus County Medical Society at his home in Dade City, May 9. A roast chicken dinner was served after which a scientific session was held. Case reports were given by Drs. Harvard, Jones, Sistrunk and Walters.

A committee was appointed to draft suitable resolutions on the death of Dr. David Mills of Zephyrhills. Doctor Walters reported on the annual meeting of the State Association.

Present at this meeting were: Drs. Edward H. Brown, J. T. Bradshaw, Claude L. Carter, S. C. Harvard, G. R. Creekmore, W. W. Jones, R. D. Sistrunk, and W. H. Walters.

The Pasco-Hernando-Citrus County Medical Society is now on the Honor Roll of 100% paid societies. Officers for this year are: W. H. Walters, Lacoochee, president; W. B. Moon, Crystal River, 1st vice-president; S. C. Harvard, Brooksville, 2nd vice-president; and George R. Creekmore, Brooksville, secretary-treasurer.

\* \* \*

### PINELLAS

On May 3, the Pinellas County Medical Society held a meeting at the Shrine Club, St. Petersburg. Dr. J. A. Bradley was the featured speaker, presenting a paper on "Use of Levin Tube." Dr. Earl C. MacCordy, chairman of the Southeastern Section of the American Congress of Physical Therapy, gave information regarding the meeting of that organization scheduled for May 20-21 in Atlanta. Delegates to the convention of the Florida Medical Association held in Tampa, April 29 - May 1 gave a report on that meeting.

At the meeting of the Society held on the evening of May 15, Dr. R. J. Needles was principal speaker. He presented a paper on "Hyperactive Carotid Sinus Reflex".

\* \* \*

### ST. LUCIE-OKEECHOBEE-INDIAN RIVER-MARTIN

This Society is right out in front. On its roll are 19 members, all with dues paid for 1940. The activities of the Society are guided this year by F. A. Gowdy, president; J. B. Kollar, vice-president; and A. M. Sample, secretary-treasurer. Congratulations!

\* \* \*

### VOLUSIA

The May meeting of the Volusia County Medical Society, held May 12, took the form of a barbecue at the Ocean Dunes Club. All members of the American Medical Association in the county, as well as members of the Society, were invited.

## ABSTRACT DEPARTMENT

*Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.*

**Transsection of the Deep Association Fibres of the Prefrontal Lobes in Certain Mental Disorders, LYERLY, J. G., Jacksonville, South. Surgeon 8: 426-434 (October), 1939.**

This paper deals with an operation which has been devised for the relief of symptoms of mental disease of the cyclothymic type.

Because the prefrontal lobes of the brain appear to play a great part in the psychic activity of the individual it seemed reasonable to suppose that cutting the deep association tracts from the frontal lobes to the rear of the brain might cause a reduction in psychic activity which is so marked in this class of mental patients. The operation consists of cutting the middle portion of the second frontal convolution on each side. The brain is exposed and opened to the white matter and prefrontal lobes and the incisions are made from one side to the other. This procedure severs the deep association pathways just anterior to the lateral ventricles. It leaves intact the posterior part of the prefrontal lobe which explains why these patients do not have any serious mental deficit after the operation. Successful results in fourteen cases of involutional melancholia are described.

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## PRESIDENT'S LETTER

I am deeply grateful for the privilege of being your president, and having the honor of working with the Doctors' wives of Florida. With the cooperation of the State and each of the County departments, we shall hope for a splendid year.

We are planning to have meetings at the same time the Doctors have their district meetings. I do hope each district will be represented with 100 per cent of its members. The meetings will be as follows:

Northwest District (A)—Pensacola, Oct. 5, 1940.  
North Central District (B)—Lake City, October 4, 1940.  
N. E. District (C)—Daytona Beach, Oct. 3, 1940.  
Southwest District (D)—Dunedin, Oct. 31, 1940.  
South Central District (E)—Ft. Pierce, Nov. 1, 1940.  
S. E. District (F)—Miami, Nov. 2, 1940.

In preparation for the coming year's work, may I suggest that you have your Hygeia chairman, Health Institute, Publicity, Philanthropic and other chairmen appointed early.

The Board meeting date has not been set, but the meeting will be held as soon as possible. All county presidents and state officers will be notified.

If at any time I can be of service in any way, please call upon me.

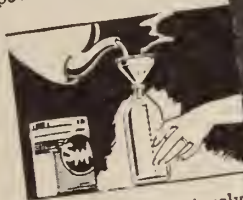
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OF SYPHILIS, GONORRHEA AND VENEREAL DISEASES, Vol. 23, No. 2, pages 201-206, March, 1939.

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COMPONENT SOCIETIES BY DISTRICTS

| COUNTY SOCIETIES                                  | PRESIDENT                                                           | SECRETARY                                                          | MEETING DATE                                                           | MEMBERS |      | COUNCILORS AND DATES OF MEDICAL DISTRICT MEETINGS        |
|---------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------|------------------------------------------------------------------------|---------|------|----------------------------------------------------------|
|                                                   |                                                                     |                                                                    |                                                                        | Total   | Paid |                                                          |
| Bay                                               | Amsie H. Lisenby, M.D.<br>Panama City                               | William C. Roberts, M.D.<br>Panama City                            |                                                                        | 11      | 100% | A-1-'42<br>W. C. Roberts, M.D.<br>Panama City            |
| Eacambia<br>*Santa Rosa                           | Sidney G. Kennedy, M.D.<br>511 American Nat. Bk. Bldg.<br>Pensacola | W. E. Tugwell, M.D.<br>Box 860<br>Pensacola                        | 2nd Tuesday<br>8:00 P. M.                                              | 44      | 35   |                                                          |
| Walton-Okaloosa                                   | A. G. Williams, M.D.<br>Lakewood                                    | R. B. Spires, M.D.<br>DeFuniak Springs                             | 3rd Thursday<br>8:00 P. M.                                             | 6       | 100% | Northwest District (A)<br>Pensacola<br>Oct. 5, 1940      |
| Washington-Holmes                                 | R. H. Segrest, M.D.<br>Bonifay                                      | L. H. Paul, M.D.<br>Bonifay                                        |                                                                        | 8       | 5    |                                                          |
| Franklin-Gulf                                     | Thos. Meriwether, M.D.<br>Wewahatchka                               | J. R. Norton, M.D.<br>Port St. Joe                                 | 3rd Thursday                                                           | 7       | 100% | A-2-'41<br>B. A. Wilkinson, M.D.<br>Tallahassee          |
| Jackson<br>*Calhoun                               | W. R. Wandek, M.D.<br>Marianna                                      | K. N. Joyner, M.D.<br>Marianna                                     | 2nd Tuesday<br>7:30 P. M.                                              | 12      | 9    |                                                          |
| Leon-Gadsden-Liberty-<br>Wakulla-Jefferson        | Francis T. Holland, M.D.<br>208 Midyette-Moor Bldg.<br>Tallahassee  | B. A. Wilkinson, M.D.<br>Telephone Bldg.<br>Tallahassee            | Quarterly<br>3:00 P. M.                                                | 40      | 38   |                                                          |
| Columbia<br>*Baker, Hamilton                      | L. J. Arnold, Jr., M.D.<br>Lake City                                | Harry S. Howell, M.D.<br>Blanche Hotel Annex<br>Lake City          | 1st Monday<br>7:30 P. M.                                               | 14      | 8    | B-3-'41<br>W. S. Nichols, M.D.<br>Lake City              |
| Madison-Suwannee                                  | J. M. Price, M.D.<br>Live Oak                                       | I. H. Black, M.D.<br>Live Oak                                      |                                                                        | 9       | 5    |                                                          |
| Taylor<br>*Dixie, Lafayette                       | J. L. Weeks, M.D.<br>Perry                                          | John C. Ellis, M.D.<br>Perry                                       | Last Friday<br>8:00 P. M.                                              | 7       | 6    |                                                          |
| Alachua<br>*Bradford, Gilchrist<br>Union          | Edwin H. Andrews, M.D.<br>134 N. Pleasant St.<br>Gainesville        | J. Maxey Dell, Jr., M.D.<br>333 W. Main St., S.<br>Gainesville     | 2nd Wednesday<br>7:30 P. M.                                            | 30      | 21   | B-4-'42<br>J. L. Summerlin, M.D.<br>Gainesville          |
| Marion<br>*Levy                                   | Henry O. Dozier, M.D.<br>9 No. Magnolia St.<br>Ocala                | It. C. Cumming, M.D.<br>Commercial Bank Bldg.<br>Ocala             | 3rd Thursday<br>12:30 P. M.                                            | 24      | 100% |                                                          |
| Pasco-Hernando-<br>Citrus                         | Wm. H. Walters, Jr., M.D.<br>Lacoochee                              | G. R. Creekmore, M.D.<br>Brooksville                               | 2nd Thursday<br>7:00 P. M.                                             | 14      | 100% | North Central District (B)<br>Lake City<br>Oct. 4, 1940  |
| Duval<br>*Clay, Nassau                            | Chas. B. Mabry, M.D.<br>439 St. James Bldg.<br>Jacksonville         | Lauren M. Sompayrac, M.D.<br>459 St. James Bldg.<br>Jacksonville   | 1st Tuesday<br>8:15 P. M.                                              | 180     | 179  | C-5-'41<br>R. B. Melver, M.D.<br>Jacksonville            |
| St. Johns                                         | Donald T. Rankin, M.D.<br>East Coast Hospital<br>St. Augustine      | Vernon A. Lockwood, M.D.<br>East Coast Hospital<br>St. Augustine   | 3rd Tuesday<br>8:30 P. M.                                              | 10      | 9    | N. E. District (C)<br>Daytona Beach<br>Oct. 3, 1940      |
| Putnam                                            | G. M. Zeagler, M.D.<br>Glendale Hospital<br>Palatka                 | Bernard E. Kane, M.D.<br>Crescent City                             | 2nd Tuesday in<br>Feb., April, June,<br>Aug., Oct., Dec.<br>7:00 P. M. | 12      | 8    | C-6-'42<br>Maximilian Stern, M.D.<br>Daytona Beach       |
| Volusia<br>*Flagler                               | L. V. L. Brown, M.D.<br>DeLand                                      | R. L. Miller, M.D.<br>258½ S. Beach St.<br>Daytona Beach           | 2nd Tuesday<br>7:30 P. M.                                              | 42      | 35   |                                                          |
| Hillsborough                                      | John R. Bolling, M.D.<br>1207 First Nat. Bk. Bldg.<br>Tampa         | James S. Grable, M.D.<br>811 Citizens Bank Bldg.<br>Tampa          | 1st Tuesday<br>8:00 P. M.                                              | 112     | 96   | D-7-'41<br>W. C. McConnell, M.D.<br>St. Petersburg       |
| Manatee                                           | M. M. Harrison, M.D.<br>Professional Bldg.<br>Bradenton             | W. E. Wentzel, M.D.<br>Box 245<br>Bradenton                        | 3rd Tuesday<br>7:00 P. M.                                              | 14      | 100% |                                                          |
| Pinellas                                          | John A. Herring, M.D.<br>259 Third St., No.<br>St. Petersburg       | W. C. McConnell, M.D.<br>813 First Federal Bldg.<br>St. Petersburg | 1st and 3rd Fridays<br>6:30 P. M.                                      | 105     | 100% |                                                          |
| Sarasota                                          | Millard B. White, M.D.<br>151 S. Pineapple Ave.<br>Sarasota         | Stanley T. Martin, M.D.<br>Sarasota                                | 2nd Tuesday<br>8:30 P. M.                                              | 16      | 6    | Southwest District (D)<br>Dunedin<br>Oct. 31, 1940       |
| DeSoto-Hardee-High-<br>lands-Charlotte-<br>Glades | Hartley E. Boorom, M.D.<br>37-38 S. Ridgeway Drive<br>Sebring       | Howard V. Weems, M.D.<br>22 Oak St.<br>Sebring                     | 2nd Tuesday<br>8:00 P. M.                                              | 21      | 100% | D-8-'42<br>H. V. Weems, M.D.<br>Sebring                  |
| Lee<br>*Collier, Hendry                           | A. S. Byle, M.D.<br>311 2nd St.<br>Fort Myers                       | Fred D. Bartleson, M.D.<br>Fort Myers                              | 3rd Friday<br>7:30 P. M.                                               | 14      | 100% |                                                          |
| Polk                                              | Henry Fuller, M.D.<br>Mulberry                                      | Jere W. Annis, M.D.<br>Box 1021<br>Lakeland                        | 2nd Wednesday<br>1:00 P. M.                                            | 62      | 56   |                                                          |
| Brevard                                           | I. M. Hay, M.D.<br>Melbourne                                        | I. K. Hicks, M.D.<br>Melbourne                                     | 3rd Tuesday                                                            | 11      | 10   | E-9-'42<br>J. R. Chappell, M.D.<br>Orlando               |
| Lake<br>*Sumter                                   | W. L. Ashton, M.D.<br>Umatilla                                      | Oliver Emerson, M.D.<br>Tavares                                    | 1st Thursday<br>12:30 P. M.                                            | 18      | 11   |                                                          |
| Orange<br>*Osceola                                | Chas. J. Collins, M.D.<br>209 Exchange Bldg.<br>Orlando             | Fred Mathers, M.D.<br>Box 53<br>Orlando                            | 3rd Wednesday<br>8:30 P. M.                                            | 84      | 83   |                                                          |
| Seminola                                          | Wade H. Garner, M.D.<br>Sanford                                     | Douglas G. Scott, M.D.<br>212 N. Park Ave.<br>Sanford              | 2nd Monday<br>7:00 P. M.                                               | 13      | 100% | South Central District (E)<br>Ft. Pierce<br>Nov. 1, 1940 |
| St. Lucie-Okeechobee<br>Indian River-Martin       | Francis A. Gowdy, M.D.<br>Ft. Pierce                                | Adrian M. Sample, M.D.<br>Ft. Pierce                               | 3rd Thursday<br>8:00 P. M.                                             | 19      | 100% | E-10-'41<br>A. M. Sample, M.D.<br>Ft. Pierce             |
| Broward                                           | L. B. Elliston, M.D.<br>814 Sweat Bldg.<br>Ft. Lauderdale           | E. C. Chamberlain, M.D.<br>720 Sweet Bldg.<br>Fort Lauderdale      | 4th Wednesday<br>8:00 P. M.                                            | 33      | 37   | F-11-'42<br>R. L. Elliston, M.D.<br>Ft. Lauderdale       |
| Palm Beach                                        | James H. Pittman, M.D.<br>Box 602<br>W. Palm Beach                  | C. Jennings Derrick, M.D.<br>Box 574<br>W. Palm Beach              | 4th Monday<br>8:00 P. M.                                               | 64      | 100% |                                                          |
| Dade                                              | Joseph S. Stewart, M.D.<br>525 duPont Bldg.<br>Miami                | Frans Stewart, M.D.<br>525 duPont Bldg.<br>Miami                   | 1st Tuesday<br>8:30 P. M.                                              | 309     | 220  | F-12-'41<br>Kenneth Phillips, M.D.<br>Miami              |
| Monroe                                            | Harry C. Galey, M.D.<br>532 Fleming St.<br>Key West                 | W. R. Warren, M.D.<br>511 Eaton St.<br>Key West                    | 1st Sunday<br>9:00 P. M.                                               | 5       | 100% | S. E. District (F)<br>Miami<br>Nov. 2, 1940              |

\*Supervise and aid until organized separately.

# He Likes PABLUM

It is a fortunate provision of Nature that at the time the infant is ready to receive the nutritional benefits of cereal, his taste is unspoiled by sweets, pastry, condiments, tobacco, alcohol and other things to which adult palates and constitutions have become conditioned.

Many a parent, with limited knowledge of nutrition, attempts to do the baby's tasting for him. Partial to sweets, the mother sweetens her child's cereal. Disliking cod liver oil, she wrinkles her nose and sighs: "Poor child, to have to take such awful stuff!" The child is quick to learn by example, and soon may become poor indeed—in nutrition, as well as in mental habits and psychological adjustment.

Appreciating the importance and difficulties of the physician's problem in establishing and maintaining good eating habits, Mead Johnson & Company continue to supply Pablum in its natural form. No sugar is added. There is no corresponding dilution of the present protein, mineral and vitamin content of Pablum. Is this not worth while?



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**PABLUM IS NOW SUPPLIED IN TWO NEW SIZES:**  
(1) 1 lb. 2 oz., replacing the 1 lb. size, and offering 2 extra ounces without additional charge; and (2) the new ½ lb. size. This size is small enough to be

easily grasped in one hand, is convenient for traveling, and requires only a small outlay of money. Both sizes are more economical in comparison with the former 1 lb. size.











